Executive Summary of Cabinet for Health Services' Grant Application

Cabinet for Health Services' Department/Division as the Applicant:
Department for Public Health/Division of Maternal and Child Health

Project Contact:
Project Manager: Brenda English-on FMLA, Vanessa Brewer-Interim
Branch Manager: Sandy Fawbush, RN

Title of Grant:
Maternal, Infant and Early Childhood Home Visiting Program (MIECHV) in Kentucky-Competitive Application

Federal Agency/Department Awarding Funding under the Grant:
US Department for Health and Human Services; Health Resources and Services Administration, Administration for Children and Families

Federal Identifier Grant No: Announcement No: HRSA-11-179; CFDA Number 93.505

Catalog of Federal Domestic Assistance: 93.505

Type of Grant Application: The Affordable Care Act Maternal, Infant, and Early Childhood Home Visiting Program federal grant funding was initially awarded in July of 2010. This funding opportunity has been a 4 step process. First, Initial application and funding was calculated for each state at a set amount/allocation. Second, a needs assessment was required to be completed to identify "at-risk" communities and evaluate the home visiting capacity in these areas. A third requirement was to submit an "updated state plan" that detailed the plan for the funding of "at-risk" communities identified in the needs assessment; in Kentucky this was 9 counties at highest risk. (Submitted in June). This current application is for additional competitive funding to expand current home visitation in the state, and is in addition to the initial allocation grant.

Beth Jurek, Policy Advisor

DPH Budget Analyst

Purpose of Grant: The primary purpose of the ACA Maternal, Infant and Early Childhood Home Visiting legislation is to strengthen and improve the programs and activities carried out under Title V; to improve coordination of services for at-risk communities; and to identify and provide comprehensive home visiting services to improve outcomes for families who reside in at-risk communities. This grant responds to the diverse needs of children and families in communities at risk and provides unprecedented opportunity for collaboration and partnership at the Federal, State and community levels to improve health and development outcomes for at-risk children through evidence-based home visiting program.

Amount of Funds this Application:

Federal Funds	
Applicant Funds	$6,971,342
State Funds	
Local Funds	
Other	
TOTAL FUNDS:	**$ 6,971,342**

Budget Details:

Personnel	$ 38,760
Fringe	$ 16,667
Travel	$ 5,000
Equipment	$ 2,500
Supplies	$ 1,500
Contracts	$ 6,898,388
Consultants	$
Other	$
Total Direct	$ 6,962,814
Total Indirect	$ 8,527
TOTAL	$ 6,971,342

Last Status Report/Summary Included: N/A

Narrative Summary:

The Kentucky Department for Public Health (DPH) will implement the MIECHV federal grant based on the results of the statewide needs assessment. In the needs assessment process, DPH created a composite score from the required indicators in the legislation by creating z-scores, and then ranked each of KY's 120 counties according to their composite score. Following this ranking, through a stakeholder meeting discussion, 20 of the highest risk counties as potential communities to target were identified. In the original application, these counties were narrowed to only 9 based on budget, community readiness, and existing capacity that would enable rapid expansion. The Updated State Plan described a 9-county pilot project creating systems of care and expanding home visitation services in the highest risk counties: Owsley, Lee, Wolfe, Leslie, Letcher, Knott, Perry, Breathitt and Lawrence Counties. For this competitive application we will plan to expand home visitation by adding 39 more at risk counties to the target area based on the needs assessment scores as to their risk. These include: Edmonson, Butler, Metcalfe, Mason, Jackson, Harlan, Clay, Bell, Rockcastle, Bath, Menifee, Rowan, Morgan, McCreary, Cumberland, Grayson, Elliott, Carter, Trigg, Fulton, Ballard, Hickman, McCracken, Nicholas, Magoffin, Martin, Floyd, Johnson, Pike, Powell, Lewis, Knox, Whitley, Montgomery, Estill, Boyd, Garrard, Monroe, Fleming (map of counties included).

The goal of the proposed expansion of KY's MIECHV program will be threefold: (A) to expand an evidence based model of maternal and early childhood home visiting to serve more at risk families, not limiting to first time parents and (B) to build home visiting systems of care to support families in these highest risk communities identified in the needs assessment, and (C) Provide mental health services through home visiting to address the risks associated with untreated perinatal depression for mother and child of those who screen positive.

(A) Goals and Objectives of the Home Visiting Model Expansion
- Positive Pregnancy Outcomes
- Optimal child growth and development
- Children live in healthy, safe homes
- Family self-sufficiency

(B) Goals and Objectives of Building Home Visiting Systems of Care
- Create a coordinated, high quality system of care for mothers and young children in high risk communities to identify at risk families and get them to the appropriate home visiting or other needed services

(C) Goals and Objectives of Perinatal Depression Home Visiting Intervention
- To address perinatal depression so that it does not adversely impact parent-infant bonding, child development, family functioning, or risk of child abuse.

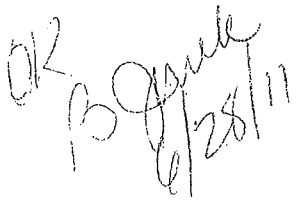
HRSA requires use of evidence-based home visiting models with this funding and they have approved seven models as evidence-based. Healthy Families America (HFA) is one of the approved models. Kentucky's HANDS program was largely based on this model when it was developed, with an addition of a health focus. In the project area, the current HANDS program in the local health departments (LHD) will affiliate with HFA. This funding will provide LHD the resources to pay the costs associated with this process, as well as expanding the current program to any at risk eligible family identified in the community. The HANDS program has also submitted studies to be determined an evidence-base model by HRSA and is awaiting the decision on this.

The mental health component of this implementation will be using a model that has been implemented and studied in the Northern Kentucky/Cincinnati area through the HFA program Every Child Succeeds/ Cincinnati Children's Hospital. Cincinnati Children's staff will provide training and on-going technical assistance for this component of the home visiting implementation, which is included in the budget.

DUE DATE TO THE FEDERAL GRANTING AGENCY: July 1, 2011

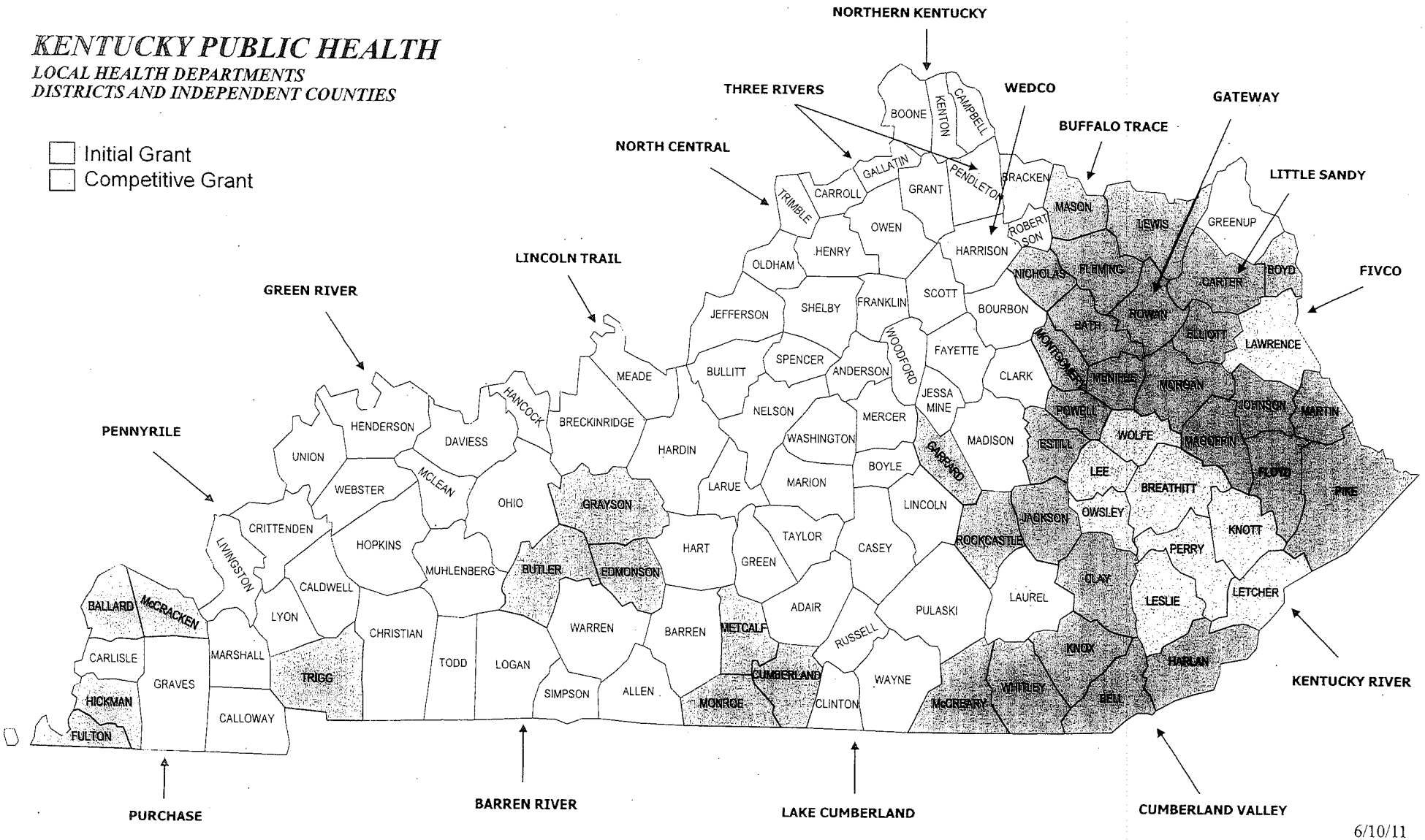
Date of Submission to Secretary

Signature of Project Manager



KENTUCKY PUBLIC HEALTH

LOCAL HEALTH DEPARTMENTS
DISTRICTS AND INDEPENDENT COUNTIES



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INTRODUCTION

A brief description of the project's proposed purpose;

The Kentucky Department for Public Health, DPH, was designated by Governor Steve Beshear to be the state agency to apply for funding through the Affordable Care Act, which amended Title V of the Social Security Act to create the Maternal, Infant, and Early Childhood Home Visiting Program. Through the process of an application, a state needs assessment and an updated plan, DPH will strive to build a high-quality, comprehensive early childhood system for pregnant women, parents and caregivers, and young children to assure that each individual can reach their full potential for health and well-being throughout the course of their lives, regardless of their societal context.

DPH will implement the MIECHV federal grant based on the results of the statewide needs assessment. In the needs assessment process, DPH created a composite score from the required indicators in the legislation by creating z-scores, and then ranked each of Kentucky's 120 counties according to their composite score. In reviewing the variables, it became evident that the entire state is particularly at-risk and in need of improved home visiting services. This was validated by the qualitative information in the needs assessments from the Title V MCH program, the Head Start Collaboration Office, and a survey of the regional CAPTA agencies.

The goals of the existing MIECHV are to expand the current evidence-based early childhood home visiting program, HANDS, to serve all at-risk families; develop a home visiting systems of care to promote health and well-being for pregnant women, children and their families; and to provide mental health services through home visitation to address the risks associated with untreated perinatal depression.

Initially twenty of the highest risk counties were identified as target communities indicating that these communities show an exceptionally high rate of teen pregnancies, tobacco users in the home, substance abuse, grandparents raising children and out of home placement, poverty, depression/poor mental health, unemployment and lack of transportation. Subsequently, the number of counties was narrowed due to funding limitations. Therefore, the existing MIECHV will target nine at-risk counties (Breathitt, Knott, Lawrence, Lee, Leslie, Letcher, Owsley, Perry and Wolfe) as identified by local stakeholders.

The purpose of this project is to expand and enhance the existing evidenced-based early childhood home visitation program, HANDS, in 39 additional at-risk Kentucky counties (Fulton, Hickman, Ballard, McCracken, Trigg, Butler, Grayson, Edmonson, Metcalf, Monroe, Cumberland, McCreary, Whitley, Knox, Bell, Harlan, Clay, Jackson, Rockcastle, Garrard, Estill, Powell, Montgomery, Menifee, Bath, Nicholas, Fleming, Mason, Lewis, Carter, Boyd, Martin, Pike, Floyd, Johnson, Magoffin, Morgan, Elliott, and Rowan) as identified on the statewide needs assessment in order to improve outcomes for vulnerable children and families. The goals of the program are equivalent to the existing MIECHV: expansion of the existing evidence-based early childhood home visitation program to serve all at-risk families; creation of a home visitation system of care; and providing mental health services to address perinatal depression.

A description of the state's history of significant progress towards implementing a high quality home visiting program, in a comprehensive high-quality early childhood system;

Health Access Nurturing Development Services (HANDS) is Kentucky's statewide home visitation program. The program was initiated in 1999 as a pilot project in fifteen sites within county health departments. The program expanded rapidly to include 47 sites by 2000 and 103 sites in 2001. By 2003 the HANDS program was available in every county in Kentucky and has since become one of the largest early childhood home visitation programs in the nation.

The HANDS program is based on the Hawaii Healthy Start and Healthy Families America models. The goals of the program are positive pregnancy outcomes, optimal child growth and development, healthy/safe homes (less child abuse and neglect) and family self-sufficiency. HANDS has a focus on infant mental health in regards to bonding and attachment and the parent-child relationship. HANDS also includes preventive health education as a critical component. Participating families must be first time parents who are overburdened. Administered by the Department for Public Health through local health departments, the program serves approximately 11,000 families annually through intensive home visitation across the state. Funding for the HANDS program became possible through the KIDS NOW Initiative (State Tobacco Funds). In February 2002, a revised State Plan to Federal Medicaid allowed Kentucky to bill HANDS services under targeted case management, allowing DPH to use state tobacco dollars to leverage for Federal Medicaid funding. As a result, funding became fee for service, as State Tobacco Funds were leveraged to bring in millions of federal Medicaid funds to Kentucky. The federal government provides seventy cents of every Medicaid dollar generated through HANDS. Kentucky will continue to put forth $8.3 million dollars annually for home visitation services to first-time parents which is the baseline for meeting the Maintenance of Effort as described in the SIR as of March 23rd, 2010.

HANDS independent evaluations have shown program effectiveness for many of the desired outcomes of the ACA legislation including improved pregnancy outcomes, including fewer premature births, fewer low birth weight and very low birth weight babies and fewer babies born with birth defects; reduction in child maltreatment; reduction in infant mortality; improved child and family functioning; reduction in repeated use of emergency rooms; reduction in risks; increases in material education and employment; and improved home safety. As a result these evidence-based outcomes have gained national recognition from organizations such as NACCHO (National Association of City and County Health Officials), ASTHO (Association of State and Territorial Health Officials), ASTLHLO (Association of State and Territorial Local Health Liaison Officials), and Great Kids, Inc.

Kentucky's existing infrastructure for early childhood systems of care includes the support of 65 Early Childhood Councils across the state, where these programs and other partners meet regularly in their communities to coordinate services and identify gaps in the system. Most communities have worked out collaborations where families identified as in-need can be assigned to the most appropriate program to address their needs. This is particularly evident in the collaboration between the Federal Healthy Start Programs and local HANDS programs in those communities that work seamlessly together to serve families.

Other infrastructure in the state, which will support effective implementation of state-wide home visiting programs and services, is the decade of experience the Department for Public Health has had in administering the HANDS program. This includes existing systems for state-wide training, technical assistance, quality assurance, and a web based data system for encounter data. The program standards are regularly reviewed and validated by early childhood education specialists to assure science-based practice. Caseload and regular supervision are well established program standards, as well as quality assurance site visits and data reports to assure fidelity to the model.

In addition, partners representing current home visiting programs, various agencies and individuals invested in early childhood outcomes have been engaged in the existing MIECHV grant process at several levels and have supplied information for this application. Partners participating directly include the MCH Division, HANDS program, Early Childhood Education, Substance Abuse in Pregnancy program, Head Start Collaboration Office, Substance Abuse Division, Child Care, CBCAP (CAPTA) agency, Early Childhood Mental Health, Kentucky's System to Enhance Early Development (KY SEED), and the Early Childhood Comprehensive Systems Grant coordinator.

A clear description of the problem, the proposed intervention, and the anticipated benefit of the project;

The Commonwealth of Kentucky has many health challenges. According to *2009 America's Health Rankings*, Kentucky ranks 41st in the nation. This is reflected in the required indicators for the needs assessment: Kentucky ranks 46th in preterm birth, 44th in low birth weight babies, and 49th in smoking in pregnancy. Although Kentucky's infant mortality runs close to the national average, deaths from child abuse are higher in Kentucky than anywhere else in the nation. Nearly one in four Kentucky children lives in poverty. Substance abuse is prevalent statewide, and a leading concern in communities. In examining Kentucky's state data report, it is clear that the entire state should be considered a community at-risk. Because the state already has an existing home visitation infrastructure present in every county in the state, Kentucky has the opportunity to address the needs and gaps identified from these indicators state-wide through enhancements to the existing HANDS program.

The focus of the competitive grant funds will be to expand the scale and scope of the existing evidence-based home visiting program (HANDS) in 39 additional Kentucky counties identified as at-risk. The first priority for the identified at-risk counties will be to expand the existing home visitation program to serve mutligravida families regardless of income, to improve outcomes for vulnerable children and families. Expectations for fiscal year 2011 are to serve 1,856 families and provide 29,688 visits; in fiscal year 2012, 2,783 families and 44,532 visits; in fiscal year 2013 and ongoing the expectation is to serve 4,124 families and provide 65,984 home visits.

The proposed project will also focus on building and implementing a home visiting system of care to ensure that families receive services appropriate for their unique needs. In order to achieve this goal a universal screening tool must be developed to identify and assist families in obtaining essential services. A universal screen will assure clear communication and

coordination between programs to guarantee that the needs of all families are identified and will assist in the prevention of unnecessary duplication of services.

Lastly, this project will address mental health. Research has demonstrated that depression in the postpartum period occurs in about 26% of high risk mothers. In populations served by home visitation, prevalence is up to 50%. Depression undermines effective nurturant parenting, interferes with normal child development, and negatively impacts home visitation outcomes. All women in the program will be screened for perinatal depression using the Edinburgh Postnatal Depression Scale. Women who screen positive will be referred to the Maternal Depression Treatment Program (MDTP). The MDTP is a comprehensive approach to identifying and treating depression in mothers participating in home visitation. Implementation of the MDTP involves three phases; (I) Implementation, (II) Training, and (III) Ongoing Consultation and Support. During Phase I, the Early Childhood Mental Health Program will work with the identified sites to construct the infrastructure and prepare sites to correctly implement the perinatal depression program. This includes training home visitors and supervisors in the identification and response to maternal depression, establishment of referral procedures, data collection and management, and how to work with the therapists to optimize outcomes for mothers and children. During Phase II, a three –day In-Home Cognitive Behavior Therapy (IH-CBT) training will be provided to therapists and the onsite doctoral-level supervisor in Cincinnati. In Phase III, ongoing consultation and support will be provided to therapists, the on-site supervisor and sites. This will include regularly scheduled site visits and telephone calls to discuss issues related to treatment, implementation changes and to compare and contrast Kentucky's performance.

Logic Model. See Attachment.

NEEDS ASSESSMENT

The current HANDS program was initiated in 1998 and 1999 with a pilot project in fifteen demonstration sites within county health departments across the Commonwealth of Kentucky. It was expanded to 47 programs in fiscal year 2000 and 103 programs in fiscal year 2001. The program became available in every county (120) in Kentucky by fiscal year 2003 and has maintained that status continuously since then.

This statewide program conducts home visits to first time parents who are found to be at risk or over burdened. HANDS is a voluntary, intensive home visitation program designed to assist parents at critical development points beginning prenatally and following a child until two years of age. Program goals for HANDS are positive pregnancy outcome, optimal child growth and development, healthy safe homes, and family self-sufficiency.

With the recent federal home visitation funding awarded we are working to expand services to include home visitation opportunities to multigravida mothers and to provide in home consultation from a mental health professional for any family identified with depression and/or domestic violence. Funding has provided the resources to implement expansion in nine of our

highest at-risk counties/communities: Letcher, Knott, Perry, Leslie, Breathitt, Owsley, Lee, Wolfe and Lawrence.

Process for determining "At Risk" Communities

Per the ACA legislation, Kentucky evaluated 12 indicators of risk, both for the state compared to the nation, and for each county compared to the state average. Kentucky collected all of the data needed to measure each of the required needs assessment data elements. This was facilitated by existing relationships with other state agencies such as the Kentucky State Police, Kentucky Injury Prevention Research Center, Medicaid Services, and the Department for Community Based Services (DCBS) that maintain data required by the needs assessment. Our data collection extended to national data sources such as National Child Abuse and Neglect Data System (NCANDS), the Substance Abuse and Mental Health Services Administration (SAMHSA) sub-state treatment planning data reports, and the Behavioral Risk Factor Surveillance System (BRFSS). We used 2008 data for most indicators. Data from vital statistics, which is housed in the DPH, is complete for 2008. Other data obtained from outside DPH used the most recent data available as listed in the data tables.

Stakeholders and partners

Kentucky has already established significant infrastructure in early childhood programs and built long-term relationships with agencies and individuals invested in early childhood outcomes. Meetings with stakeholders and partners started in late June 2010. Partners participating directly in this process include the MCH Division, HANDS program, Early Childhood Education, Substance Abuse in Pregnancy program, Head Start Collaboration Office, Substance Abuse Division, Child Care, CBCAP (CAPTA) agency, Early Childhood Mental Health, Kentucky's System to Enhance Early Development (KY SEED), and the Early Childhood Comprehensive Systems Grant coordinator.

In addition, partners representing various home visiting programs in the state have been engaged in this process at several levels and have supplied information for this application. Representatives from each of the current home visiting programs were brought together to review the needs assessment, assure the accuracy of the information regarding their program, and provide feedback about the potential framework for addressing the gaps in early childhood home visiting and needs of priority populations in high risk communities. This occurred in August at the Infant Toddler Institute, where Kentucky's early childhood professionals from a wide array of programs gather annually for a combined professional development conference. A broader group of stakeholders, including representatives from home visiting programs in the state, was invited to a meeting on August 18, 2010 to review the data and consider gaps in home visiting in the state.

Scoring/Ranking Methodology

We created a matrix with all of Kentucky's 120 counties and all of the indicators required in the ACA legislation. This enabled easy identification of any one county or one topic where the data indicates need, and a ranking of which areas have the greatest needs. The MCH Epidemiology Team met with the DPH Epidemiology Data Users Group in June to discuss methodologies for ranking. Data Users Group brings together all personnel currently working with data (epidemiologists, evaluators, and analysts) or *interested* in data for educational trainings and

presentations. On July 6, 2010 an ad hoc group of epidemiologists met to discuss potential strategies for the ACA Home Visiting Needs Assessment.

In order to analyze the multiple types of measurement in this data, we devised a methodological plan that captures the variation of the indicators among Kentucky's 120 counties. The first strategy was to create an unweighted summation. This would be the easiest way to capture counties at lowest and highest risk. Our plan consisted of developing a scoring system based on standard deviations from the mean for each indicator; thus allowing a composite score for each county and each topic. For the Home Visiting Needs Assessment data indicators, we calculated z-scores one standard deviation above and below the state mean for each county for every indicator. County z-scores were tallied across all indicators. Counties with increasingly positive z-scores are those that are not high risk. Counties with negative z-scores are communities at-risk.

$$\text{Z-score} = \frac{\text{(State mean for given indicator -county rate for given indicator)}}{\text{Standard Deviation for given indicator}}$$

Initial Indicator Rankings

After the z-scores were calculated, we examined every indicator. Counties were ranked based on their cumulative z-score. Table 2.1 below shows the counties from worst to best with negative numbers indicating worse score.

Legislation regarding the community needs assessment has identified twelve variables. Those twelve variables are to be considered when determining the communities in need. The guidance further defined the parameters of the presentation of these variables. From those, the metrics for the reporting of crime and substance abuse was not expected. As the guidance was published well after the legislation, initial data analysis was completed prior to legislation being released.

Correlation analysis

Next, interaction of the variables defined in the legislation was performed to determine which of these variables had the most significant impact on the overall risk score. We examined if correlations existed between the variables. Highly correlated variable could imply skewedness. Multiple highly correlated variables may imply systematic bias. Fortunately, none of the variables we examined indicated these effects.

Realistically, different variables have different amounts of effect on the outcome or weight. Therefore, a weighted z-score table would be the most accurate method to determine actual interaction on overall ranking by the defined variables. Taking the variables again, the weight of each variable was determined on the overall rank, a summation of the z-scores of the variables. To achieve this, a correlation table was developed to assess the effect of each variable on the overall rank. This interaction was then multiplied by the unweighted z-score to achieve the new weighted z-score. This was then applied to the general z-score table. This was done to correct for the equal distribution of weight each variable had on the overall ranking of Kentucky counties.

Findings from analysis show that Kentucky rates are worse than national average. Kentucky ranks lower than the national average in almost every indicator. Keeping that in mind, we looked

closer at the z-scores used in the ranking of counties. We found that fifty-one counties fall below the state average and have a negative sum of z-scores.

Below is the correlation table from the weighted z-scores that shows significant findings. Not surprisingly, poverty showed the highest correlation to the county's overall rank (0.7). The next highest correlation to overall rank was smoking in pregnancy, validating the CDC's statement that it is the most modifiable and significant risk factor for poor maternal-child health outcomes. After that, deaths from child abuse, child abuse and neglect, and prematurity all showed significant influence on the overall rank for the county. This provided valuable information for evaluating gaps and priorities.

METHODOLOGY

Kentucky will be implementing the Healthy Families America (HFA) model in the 39 counties that the state has targeted as at-risk communities. Healthy Families America (HFA) is an evidence-based, nationally recognized home visiting program model designed to work with overburdened families who are at-risk for child abuse and neglect and other adverse childhood experiences. It is the primary home visiting model designed to work with families who may have histories of trauma, intimate partner violence, and mental health and/or substance abuse issues. HFA closely mirrors Kentucky's existing HANDS program, with some modifications which are approved by the developer. The HANDS sites in the project area will officially be HFA sites, but will be administered through HANDS.

HFA is designed for parents facing challenges such as single parenthood, low income, childhood history of abuse, substance abuse, mental health issues, and/or domestic violence. Individual programs select the specific characteristics of the target population they plan to serve. Families must be enrolled prenatally or within the first three months after a child's birth.
Program focus: HFA aims to 1) reduce child maltreatment; 2) increase use of prenatal care; 3) improve parent-child interactions and school readiness; 4) ensure healthy child development; 5) promote positive parenting; 6) promote family self-sufficiency and decrease dependency on welfare and other social services; 7) increase access to primary care medical services; and 8) increase immunization rates. From Kentucky's needs assessment, child maltreatment indicators were some of the strongest influencers of the overall rank of our highest risk communities.
The HANDS program currently exists in the counties chosen for this expansion, serving only first-time parents. Expansion funds will be used to accept all high-risk parents in the targeted 39 counties, thereby eliminating one of the primary service gaps that was identified by both local and statewide collaboration partners. In addition, the need for mental health services for these families is great, and addressing them through home visiting is more likely to be successful than expecting these already overburdened mothers to seek care when offered a referral. This would be coordinated with existing mental health programs at the regional mental health centers. All of the existing early childhood programs in these communities are interested in further development of a system of care and referrals for these mothers and families with very young children.
The goals of the expansion of KY's MIECHV program will be to: (A) expand an evidence based model of maternal and early childhood home visiting to serve more families, and (B) to build home visiting systems of care to support families in these highest risk communities identified in the needs assessment, and (C) provide mental health services through home visiting to address

the risks associated with untreated perinatal depression for mother and child of those who screen positive. The addition of a mental health specialist is an adaptation of the HFA model that has been requested and approved.

Goals and Objectives
Year 1

Goal 1: Expand an evidence-based model of maternal and early childhood home visiting to serve an estimated 1856 more families (estimated 29,688 more visits).

Objective 1: Ensure the HANDS program will be in alignment to become Healthy Families America accredited.	
	Activity 1: Newly hired HFA Technical Consultant will serve as a systems coordinator and work with sites and HFA to ensure that the standards of the proven home visitation model are being upheld.
	Rationale: HANDS must maintain HFA affiliation to qualify for grant funds.
	Mechanism: All HFA self assessment tools have been obtained and necessary steps are being taken so that HANDS is ready for expansion.
Objective 2: Provide training to the additional home visitors that will be hired as a result of the program expansion	
	Activity 1: Kentucky's Training Coordinator will schedule additional training weeks regionally in the areas of home visiting basics (Family Support Worker Core Training) and parenting and child development (Growing Great Kids Curriculum Training) to accommodate increased number of home visitors.
	Rationale: New home visitors will need to be trained in order to meet the staffing needs of the sites as they expand their intake to multigravida parents.
	Mechanism: HANDS Training Coordinator will schedule trainers to provide training, secure training locations, coordinate registration and procure training materials.
	Activity 2: HANDS trainers will develop curriculum for training hours that will specifically address the needs and stresses of multiple-children homes.
	Rationale: New and current HANDS workers will need to anticipate how the additional stresses of additional children can affect families, and how the Growing Great Kids Curriculum can be used to meet those specific needs.
	Mechanism: HANDS training team will meet to develop learning objectives that accent the modules in the Growing Great Kids Curriculum that can be used to address the needs of a multiple-child home. These trainings will be delivered by Kentucky's nationally certified Growing Great Kids curriculum trainers and will be offered regionally in the expansion areas.
	Activity 3: Expand required HANDS trainings to include common challenges of multigravida families and the best ways to support multiple-children homes.
	Rationale: Discussions of the specific challenges of multigravida families will be integrated into the regular home visiting core and curriculum training weeks.
	Mechanism: HANDS state training coordinator will work with Kentucky's nationally-certified core and curriculum trainers to integrate learning objectives specific to multigravida families into the training weeks that are required of each new employee.
Objective 3: Increase awareness of HANDS expansion to multigravida families in the grant communities.	
	Activity 1: Local site coordinators will reeducate local health department staff, community early childhood partners, and local OB/GYN offices about the expansion of the HANDS program.
	Rationale: Referral sources must be notified that HANDS is no longer only for first-time

	parents in these areas.
	Mechanism: Local staff will personally meet with interested parties to inform them of project expansion and answer specific questions. HANDS staff will participate in their local Community Early Childhood Councils (CECC).
	Activity 2: All current and former HANDS families will receive notice that HANDS has expanded to serve subsequent pregnancies and families.
	Rationale: Based on data that we have collected in parent satisfaction surveys, many HANDS families will be interested in participating in the program during subsequent pregnancies and would recommend the program to friends and relatives who are pregnant or have newborn children.
	Mechanism: Sites will mail postcards or letters to current and former HANDS families to inform them of program expansion.
	Activity 3: Collaborate with Medicaid to access all records for Medicaid participants receiving prenatal services.
	Rationale: Based on current HANDS caseload, 85-90% of HANDS participants qualify for Medicaid.
	Mechanism: Medicaid participants will automatically be notified of their acceptance into the HANDS program. Their contact information will then be shared with their corresponding county so that initial contact can be made and entry can begin as early prenatally as possible. Participants will have the option to opt out of the HANDS program at any point. Services will be voluntary with the expanded population just as it is with current participants.

Goal 2: Build home visiting systems of care to support families in the 39 grant areas.

Objective 1: Guide families to the appropriate home visitation program in their area.	
	Activity 1: Create a universal screening tool that will assist in getting families to the home visitation program(s) that will be most likely to meet the family's needs.
	Rationale: Families come to parenthood with a variety of needs and circumstances, and different home visitation programs will be appropriate for them based on those needs and circumstances.
	Mechanism: The universal screening tool has been created and will be rolled out to expansion sites and communities with appropriate training.
Objective 2: Strengthen collaboration between community early childhood partners.	
	Activity 1: Utilize the Community Early Childhood Council (CECC) partner agencies (already in place and functioning) to facilitate identifying resources and filling gaps for mothers and young children.
	Rationale: All community partner agencies must work together to provide support and resources for mothers and young children.
	Mechanism: Each expanded HANDS site will be actively involved in their local CECC and use it as a vehicle for bringing together many community members to support issues of importance to children and families and to provide a coordinated system for planning and information sharing. Each CECC will be able to see the full scope and any gaps in home visiting as an integrated piece of early childhood systems of care.

Goal 3: Provide mental health services through home visiting to address the risks associated with untreated perinatal depression for mother and child of those who screen positive.

Objective 1: Add home visiting mental health clinicians to HANDS teams.	
	Activity 1: Hire 12 mental health clinicians with Masters-level training in social work,

	psychology or counseling (ML) and with prior training in Cognitive Behavioral Therapy to serve as therapists.
	Rationale: Mental health clinicians will be responsible for implementation of the Maternal Depression Treatment Program (MDTP).
	Mechanism: Clinicians will be hired and employed by local mental health centers.
	Activity 2: Ensure therapists attend a three-day Cognitive Behavioral Therapy refresher training at the Beck Institute in Philadelphia or equivalent CBT immersion experience prior to participating in the Program training.
	Rationale: Each clinician must start with the same information in order to ensure fidelity to the model.
	Mechanism: Clinicians will attend refresher training at the Beck Institute in Philadelphia or equivalent CBT immersion refresher training. HANDS Training Coordinator will aid in facilitating travel and registration.
	Activity 3: Clinicians will attend a three day In-Home Cognitive Behavior Therapy (IH-CBT) training in Cincinnati, Ohio.
	Rationale: Clinicians must become extensively trained in using CBT in the home as it specifically relates to women experiencing perinatal depression.
	Mechanism: Clinicians will attend this training. Registration and travel will be facilitated by HANDS Training Coordinator.
	Activity 4: Ongoing consultation and support will be provided to clinicians by Every Child Succeeds.
	Rationale: The clinicians must be supported in their work by supervisors who are experienced in the specific challenges faced by the clinicians.
	Mechanism: Every Child Succeeds will conduct regularly scheduled on-site and telephone consultation to support therapists in effectively implementing the IH-CBT. They will also review a sample of audiotapes of IH-CBT sessions to ensure quality and fidelity to the treatment model.
Objective 2: Integrate mental health specialists into existing HANDS programs to conduct the MDTP.	
	Activity 1: Construct the infrastructure and prepare sites to correctly implement the MDTP. This will include training home visitors and supervisors in the identification and response to maternal depression, establishing referral procedures, data collection and management, and how to work with the therapists to optimize outcomes for mothers and children.
	Rationale: MDTP therapists and HANDS home visitors must work as a team in order to fully meet the needs of mothers who experience perinatal depression and their families.
	Mechanism: HANDS home visitors and supervisors will receive training on the MDTP and their roles in the process.
	Activity 2: Expand required HANDS trainings to include education and expectations of the new mental health protocol.
	Rationale: Existing HANDS employees will be trained specifically on the integration of the mental health protocol into their existing systems, but new trainees will have the system introduced and explained as part of their regular home visiting core and curriculum training weeks.
	Mechanism: HANDS state training coordinator will work with Kentucky's nationally-certified core and curriculum trainers to integrate the mental health protocol seamlessly into the training weeks that are required of each new employee.

Year 2

Goal 1: Expand an evidence-based model of maternal and early childhood home visiting to serve an estimated 2783 more families (estimated 44,532 visits).

Objective 1: Provide training to the additional home visitors that will be hired as a result of the program expansion	
	Activity 1: Kentucky's Training Coordinator will schedule additional training weeks regionally in the areas of home visiting basics (Family Support Worker Core Training) and parenting and child development (Growing Great Kids Curriculum Training) to accommodate increased number of home visitors.
	Rationale: New home visitors will need to be trained in order to meet the staffing needs of the sites as they expand their intake to multigravida parents.
	Mechanism: HANDS Training Coordinator will schedule trainers to provide training, secure training locations, coordinate registration and procure training materials.
Objective 2: Increase awareness of HANDS expansion to multigravida families in the grant communities.	
	Activity 1: Local site coordinators will continue outreach program to community partners to ensure that everyone in the community is aware that HANDS accepts multigravida parents and expectant parents.
	Rationale: It will take some time for all community partners to be aware that HANDS has changed its "first time parents" policy. Ongoing communication will reeducate existing partners and educate new members of the community.
	Mechanism: Local staff will personally meet with interested parties to inform them of project expansion and answer specific questions. HANDS staff will participate in their local Community Early Childhood Councils (CECC).

Goal 2: Build home visiting systems of care to support families in the 39 grant areas.

Objective 1: Guide families to the appropriate home visitation program in their area.	
	Activity 1: Utilize the universal screening tool that will assist in getting families to the home visitation program(s) that will be most likely to meet the family's needs.
	Rationale: Families come to parenthood with a variety of needs and circumstances, and different home visitation programs will be appropriate for them based on those needs and circumstances.
	Mechanism: The universal screening tool will be used by HANDS and partner agencies.
Objective 2: Strengthen collaboration between community early childhood partners.	
	Activity 1: Utilize the Community Early Childhood Council (CECC) partner agencies (already in place and functioning) to facilitate identifying resources and filling gaps for mothers and young children.
	Rationale: All community partner agencies must work together to provide support and resources for mothers and young children.
	Mechanism: Each expanded HANDS site will be actively involved in their local CECC and use it as a vehicle for bringing together many community members to support issues of importance to children and families and to provide a coordinated system for planning and information sharing. Each CECC will be able to see the full scope and any gaps in home visiting as an integrated piece of early childhood systems of care.

Goal 3: Provide mental health services through home visiting to address the risks associated with untreated perinatal depression for mother and child of those who screen positive.

Objective 1: Support home visiting mental health clinicians within HANDS teams.	
	Activity 1: Ongoing consultation and support will be provided to clinicians by Every Child Succeeds.
	Rationale: The clinicians must be supported in their work by supervisors who are

	experienced in the specific challenges faced by the clinicians.
	Mechanism: Every Child Succeeds will conduct regularly scheduled on-site and telephone consultation to support therapists in effectively implementing the IH-CBT. They will also review a sample of audiotapes of IH-CBT sessions to ensure quality and fidelity to the treatment model.

Years 3&4

Goal 1: Expand an evidence-based model of maternal and early childhood home visiting to serve an estimated 4124 more families (estimated 65,984 visits) in each of these years.

Objective 1: Provide training to the additional home visitors that will be hired as a result of the program expansion	
	Activity 1: Kentucky's Training Coordinator will schedule additional training weeks regionally in the areas of home visiting basics (Family Support Worker Core Training) and parenting and child development (Growing Great Kids Curriculum Training) to accommodate increased number of home visitors.
	Rationale: New home visitors will need to be trained in order to meet the staffing needs of the sites as they expand their intake to multigravida parents.
	Mechanism: HANDS Training Coordinator will schedule trainers to provide training, secure training locations, coordinate registration and procure training materials.
Objective 2: Increase awareness of HANDS expansion to multigravida families in the grant communities.	
	Activity 1: Local site coordinators will continue outreach program to community partners to ensure that everyone in the community is aware that HANDS accepts multigravida parents and expectant parents.
	Rationale: It will take some time for all community partners to be aware that HANDS has changed its "first time parents" policy. Ongoing communication will reeducate existing partners and educate new members of the community.
	Mechanism: Local staff will personally meet with interested parties to inform them of project expansion and answer specific questions. HANDS staff will participate in their local Community Early Childhood Councils (CECC).

Goal 2: Build home visiting systems of care to support families in the 39 grant areas.

Objective 1: Guide families to the appropriate home visitation program in their area.	
	Activity 1: Utilize the universal screening tool that will assist in getting families to the home visitation program(s) that will be most likely to meet the family's needs.
	Rationale: Families come to parenthood with a variety of needs and circumstances, and different home visitation programs will be appropriate for them based on those needs and circumstances.
	Mechanism: The universal screening tool will be used by HANDS and partner agencies.
Objective 2: Strengthen collaboration between community early childhood partners.	
	Activity 1: Utilize the Community Early Childhood Council (CECC) partner agencies (already in place and functioning) to facilitate identifying resources and filling gaps for mothers and young children.
	Rationale: All community partner agencies must work together to provide support and

	resources for mothers and young children.
	Mechanism: Each expanded HANDS site will be actively involved in their local CECC and use it as a vehicle for bringing together many community members to support issues of importance to children and families and to provide a coordinated system for planning and information sharing. Each CECC will be able to see the full scope and any gaps in home visiting as an integrated piece of early childhood systems of care.

Goal 3: Provide mental health services through home visiting to address the risks associated with untreated perinatal depression for mother and child of those who screen positive.

Objective 1: Support home visiting mental health clinicians within HANDS teams.	
	Activity 1: At this point MDTP therapists will be wholly ingrained in the HANDS teams and will receive supervision and support from HANDS supervisory staff.
	Rationale: HANDS supervisory staff will be experienced and trained in the MDTP process and will continue to provide support to the MDTP staff.
	Mechanism: MDTP therapists will receive regular supervision as prescribed in the HFA program documents.

Work Plan

When the initial MIECHV funding opportunity was made available, a collaboration of home visiting and early childhood program specialists including representatives from First Steps Early Intervention, KIDS Now, Save the Children, Mental Health and Substance Abuse Services, the Pritchard Committee, local health departments, Public Health leadership, program staff and epidemiologist at the Kentucky Department for Public Health began looking at county data to identify areas of need and "high-risk" populations to determine which communities would benefit most should funding be awarded. With funding availability, nine counties were initially chosen for existing home visiting program expansion and enhancement to improve outcomes for vulnerable children and families.

Using this additional grant funding, Kentucky plans to (1) expand the existing evidence-based home visiting program to include 39 additional Kentucky counties identified as at-risk through the statewide needs assessment,(2) build and implement a home visiting system of care, and (3) provide mental health services through home visitation to address the risks associated with untreated perinatal depression. The 39 targeted counties are Fulton, Hickman, Ballard, McCracken, Trigg, Butler, Grayson, Edmonson, Metcalf, Monroe, Cumberland, McCreary, Whitley, Knox, Bell, Harlan, Clay, Jackson, Rockcastle, Garrard, Estill, Powell, Montgomery, Menifee, Bath, Nicholas, Fleming, Mason, Lewis, Carter, Boyd, Martin, Pike, Floyd, Johnson, Magoffin, Morgan, Elliott, and Rowan.

Program expansion in these sites will require that the current HANDS program is in alignment to become Healthy Families America (HFA) accredited. Therefore, the Kentucky Department for Public Health will hire a HFA Technical Consultant to serve as a systems coordinator that will network with grant sites and HFA to ensure that standards of the existing home visiting program are pursuant to HFA regulations. Necessary steps are currently being taken to prepare grant sites for expansion.

As the program expands to serve more at-risk families and local staff numbers increase to provide services, additional training will be needed. The Training Coordinator will work with the State Training Team to schedule required program training to address the needs of newly hired staff. The Training Coordinator will also work with the Training Team to develop curricula specifically addressing the needs and stressors of multiple-children homes. The training will accent the existing Growing Great Kids curriculum and will be delivered by Kentucky's nationally certified Growing Great Kids curriculum trainers.
Ongoing collaboration and communication between local referral sources and community partners will be essential to engage mutlitgravida families. Local HANDS site Coordinators will provide information and education regarding the expansion to local health department staff, community early childhood partners and local OB/GYN offices. Local sites will also notify current and former HANDS participants of the expansion and offer services to those interested. Because 85-90% of current HANDS participants quality for Medicaid, HANDS Central Office will collaborate with Medicaid Services to access records of those receiving prenatal services to ensure that this population is not excluded. Their contact information will then be shared with the local health department so that initial contact can be made and services can be initiated as early as possible.

Young children and their families require health, early care and education, family support and various community services in order to reach their full potential for health and well-being throughout the course of their lives. Achieving this goal extends beyond any one program or departmental responsibility and therefore requires a systemic approach. To ensure that the needs of all at-risk families are identified and met, these funds will assist in the construction and implementation of a home visiting system of care. In the construction phase, a universal screening tool must be created to assess needs and guide families to appropriate services. Collaboration between community early childhood partners will be essential in the success of the home visiting system of care; therefore community partners will work together to provide support, identify resources and fill gaps regarding services for families and children.

The need for mental health services for at-risk families is great. Research has demonstrated that depression in the postpartum period occurs in about 26% of high risk mothers. In populations served by home visitation, prevalence is up to 50%. Mental health services will be provided through home visiting to address the risks associated with untreated perinatal depression. All women in the program will be screened for perinatal depression using the Edinburgh Postnatal Depression Scale. Women who screen positive will be referred to the Maternal Depression Treatment Program (MDTP). Mental health specialists will be responsible for implementation of the MDTP; therefore twelve mental health specialist, with a Masters-level training in social work, psychology or counseling with prior training in Cognitive Behavior Therapy (CBT), will be hired for program implementation. Newly hired mental health specialists will attend a three-day Cognitive Behavior Therapy refresher training at the Beck Institute in Philadelphia or equivalent CBT immersion experience prior to providing services. They will also be required to attend a three day In-Home Cognitive Behavior Therapy (IH-CBT) training in Ohio to become extensively trained in using CBT in the home as it specifically relates to women experiencing perinatal depression. These specialists will be supervised by Every Child Succeeds (ECS); therefore, ongoing consultation and support will be provided through ECS including regularly

scheduled on-site and telephone consultation for effective implementation of the IH-CBT. HANDS home visitors and supervisors will also receive training on the MDTP for successful program implementation. Collaboration between the mental health specialist and HANDS home visitors will be essential to fully meet the needs of mothers suffering with depression.

Protocol for the expansion effort proposals will be thoroughly explained in the HANDS Handbook that is provided statewide to HANDS staff, and the current training to staff will be expanded to include multigravida information and applying the curriculum to multigravida families. HANDS staff are required to obtain continuing education each year, with a bi-annual conference provided by the state office where these new trainings will be provided. The next conference is scheduled for 2012. Other trainings scheduled by Kentucky's state training coordinator are being evaluated to expand and compliment the new audience HANDS will begin serving.

With the training enhancements, all current staff will be prepared to serve the additional participants in the 39 counties affected by multigravida enhancement by early October 2011. As enrollment increases, data will be monitored to identify counties where capacity is reached and additional staff may have to be trained as needed.

There are currently technical assistants assigned to each county that provide yearly reviews and continuous support to each county. There is also a coordinator and supervisor located at each site to provide supervision and oversight at the local level. All of the supervisory roles will continue to coordinate efforts with the state level staff which will include the newly hired state office technical assistant and the administrator or this federal grant.

Because the HANDS program operates out of every health department, in each of the counties in our identified high risk community, all staff including supervision is in place and trained to begin the initial expansion. The Early Childhood Mental Health program along with staff from the Department of Mental Health and Substance Abuse Services has been involved with the planning for the expansion of mental health intervention therefore a partnership between agencies already exists. Current plans for expansion do not require recruitment of subcontractors or other organizations for successful implementation.

Program expansion will allow HANDS to reach high risk and hard to engage populations that have with a home visitation support that has the family in mind. With the aforementioned program goals HANDS will have the opportunity to support families in improvements in maternal, child and family health. Estimating a 25% participation rate among the newly qualified multigravida families and mental health/domestic violence families and estimating a 50 % retention rate from year one participants to year two and from year two to year three in addition to the 25% each year we are estimating involvement with more than 4500 additional families. Expectations for the multigravida expansion for FY11: to serve 1,856 families and provide 29,688 visits; FY12: to serve 2,783 families and provide 44,532 visits; FY13 and ongoing: to serve 4.124 families and provide 65,984 home visits. These numbers are preliminary and close monitoring will be conducted to identify areas where maximum caseloads are being reached and appropriate measures can be taken to ensure families receive the services needed.

These services include referrals to local agencies for assistance in any area outside the scope of work of HANDS program capabilities, including but not limited to, substance abuse, tobacco cessation, domestic violence, oral health, child care and furthering educational opportunities for parents. Staff are trained to recognize signs of abuse, neglect and maltreatment and in any suspected cases official services are involved appropriately.

The epidemiologist at the Department for Public Health along with program staff have scrutinized all forms and data collection tools to identify any challenges we may face in reporting and to evaluate the questions and time frames administered to ensure all benchmark areas and domains of legislation are going to be able to be measured and monitored for continuous quality improvement. The expertise of this team has been beneficial in identifying challenges we may face in quality and ability to measure goals set forth in the benchmarks and been crucial in design of data points to be incorporated into the program to assure outcomes measurability and accuracy for future reporting. These changes are being discussed with the technology team and will be implemented into the web based data collection tool in time for expansion.

Since 1999, HANDS has put out a bid for contract for an independent firm to provide both quantitative and qualitative evaluations on the impact of HANDS services statewide. REACH (Resources for Education, Adaptation, Change and Health), Inc. of Louisville is currently under contract with the state HANDS program and will be involved with these expansion efforts to ensure that elements needed to conduct a proper evaluation are gathered, and that quality data capture procedures are in place from the beginning of the expansion. State Maternal and Child Health epidemiology teams as well as staff from the KY Injury Prevention and Research Center will be involved in assessing the needed elements and ensuring their implementation. Including the expert staff from beginning of development will help minimize the possible challenges, and provide for a refined plan and organized expansion.

Not only will the partnering efforts with experts like epidemiologist and independent data analysis teams prove beneficial, but the collaborative efforts with Medicaid will help to ensure families in need are not overlooked, and prenatal Medicaid participant are identified promptly to aid in reducing the number of premature births, low birth weights, birth defects, and instances of infant mortality.

The HANDS program is part of the Kids Now Initiative, which is transitioning into the Early Childhood Advisory Council, and they have pledged a continued 8.3 million in state funding. Kentucky recognizes the importance of home visiting and will continue its efforts. These proposed enhancements will provide the Kentucky HANDS program an exciting opportunity to positively impact families in the Commonwealth.

RESOLUTION OF CHALLENGES

Kentucky has requested adaptations to the HFA model and received approval of those adaptations. The first adaptation is to adjust the minimum length of service from three years to

two years, with the understanding that families who remain on Level 1 at two years will be offered service for three years. The second adaptation pertains to caseload size. HFA permits full-time home visitors to provide up to 15 home visits per week per full-time home visitor, with no more than a calculated case weight of 30 points. The State, in an effort to ensure each full-time home visitor completes 15 home visits per week, is permitted to have case weights higher than 30 points to accommodate the fact that State data shows approximately 25% of scheduled home visits are cancelled in any given week.

The addition of a home visiting intervention for perinatal depression will be challenging. The evidence-based home visiting intervention we intend to use was developed and tested in a HFA-HANDS site, so it is an already accepted adaptation to the HFA model. Kentucky has secured the engagement of the developers of the perinatal depression intervention to provide training and technical assistance from the model developers for this new component of the home visiting program.

It will be challenging to make all of the necessary changes to Kentucky's HANDS policies and procedures manual (Handbook). In Kentucky, this task falls to the Quality Assurance Coordinator (among many other responsibilities) and to the Technical Assistant team. This team meets once per month for one to two days and will write and review all changes to the Handbook before those changes become a permanent addition to the HANDS policies. This process is time-consuming and detailed.

It may be a challenge to find 12 Masters-level mental health specialists who have the required training and experience in the geographic regions required. The intervention communities are not as attractive to educated, experienced workers as other parts of the state. The process of finding workers with the correct skill sets and personal characteristics may be extensive. HANDS will utilize the expertise of the community mental health centers in these areas in order to find mental health specialists who will easily transition into the HANDS program.

EVALUATION AND TECHNICAL SUPPORT CAPACITY

The Access Nurturing Development Services (HANDS) program is a voluntary home visiting program that provides support and resources for parents in Kentucky from the prenatal period through the child's third birthday. The main goals of HANDS are to ensure healthy pregnancies and births, healthy child growth and development, healthy safe homes, and self-sufficient families. HANDS is available in nine Kentucky counties, and due to the positive outcomes the desire is to expand the program to serve 40 counties.

The proposed expansion of the Health Access Nurturing Development Services (HANDS) program will be evaluated based on improvements in constructs in the six core areas compared to baseline values. Data from the expanded 31 counties will be compared with data from the existing nine counties. Analyses will be conducted quarterly and the summary of the data will be provided to the HANDS administrator for distribution to local communities. An annual evaluation of all programs will be compiled at the close of the fiscal year.

The population assessed is all women enrolled in the HANDS program during the prenatal period. Any women experiencing a fetal death, miscarriage, infant death before six months of age, adoption, or parental termination of rights will be excluded.

IRB and human subjects permission are not necessary due to the surveillance nature of the data collection and evaluation and the requirement by law (KRS) to report suspected child abuse/maltreatment in the state.

The HANDS data is kept on a server housed in the Department for Public Health. Permission to view or edit the data is granted only to limited HANDS and DPH staff. HIPAA and FERPA are not applicable.

I. Improved Maternal and Newborn Health

Data will be obtained from multiple sources: live birth certificates, HANDS database, and depression screens conducted by HANDS. The live birth certificates and HANDS database are collected electronically on an ongoing basis. Analyses using these data will be completed on a quarterly basis. Data relating to depression are collected up to three times: 6-8 months prenatal, 2-8 weeks postpartum, and 8-12 months postpartum. Comprehensive reports will be completed annually.

Construct: Prenatal Care

The objective for the prenatal care construct is to increase the proportion of pregnant women served by the Health Access Nurturing Development Services (HANDS) program who receive prenatal care in the first trimester.

Improvement will be measured through a comparison between the benchmark year (year one) and subsequent years. Higher proportions of women initiating prenatal care in the first trimester compared with the baseline will be considered an improvement.

Data will be collected from the live birth certificate files obtained through the Office of Vital Statistics, which will be linked with HANDS program data. The live birth certificate includes the dates of the first and last prenatal care visit along with the number of visits. Based on gestational age of the infant and the date of birth, the trimester in which care began will be calculated. Entry into prenatal care will be grouped into four categories: first trimester, second trimester, third trimester, and no prenatal care. The data is completed by the birthing facility and is thought to be both reliable and valid for each infant.
Data will be analyzed using SAS version 9.2. Frequencies and percents will be used to summarize the data. Data will be analyzed in aggregate and by county of service, maternal age, race, and payor source for delivery. Data will be reported by the percentage of mothers initiating prenatal care by trimester.

Construct: Parental Use of Alcohol, Tobacco, or Illicit Drugs

Objectives:

1. Decrease the proportion of women served by the HANDS program who report tobacco exposure in the third trimester of pregnancy.
2. Decrease the percentage of families that report smoking in the home at the six month HANDS visit.

Improvement will be a lower proportion of women reporting smoking 1 or more cigarettes during the third trimester of pregnancy compared with the baseline year (year one), and lower proportion of families reporting smoking in the home compared with year one.

Data will be obtained through the live birth certificate and the HANDS database. The live birth certificate from the Office of Vital Statistics will be linked with the HANDS program data to provide a comprehensive source of data. The live birth certificate captures data for tobacco exposure by each trimester of pregnancy. This measure will focus on reported tobacco use during the third trimester of pregnancy. Underreporting of tobacco exposure has been documented with the live birth certificate; however these files provide a consistent measure for comparison between HANDS and non-HANDS participants. The HANDS database collects information on smoking in the home in the Family Status Worksheet. The data are obtained by personal interviews with the family conducted by a Family Support Worker who is trained to collect this type of data. The HANDS data provide a unique opportunity to assess household tobacco exposure.

Tobacco use in the third trimester and tobacco use in the home will be dichotomized into yes/no variables. Any woman reporting smoking one or more cigarettes during the third trimester and any family reporting smoking in the home will be classified as yes. Any woman who reports smoking zero cigarettes during the third trimester and any family who reports not smoking in the home will be classified as no. Unknown or missing values will be excluded from the analysis. Analyses will be conducted in SAS version 9.2. The variables will be summarized using frequencies and percentages and will be analyzed in aggregate and by county, maternal age, race, payor source, and reported tobacco exposures. Data will be reported by the percentage of mothers reporting smoking during the last three months of pregnancy and by the percentage of families reporting smoking in the home.

Construct: Preconception Care

The goal is to increase the proportion of mothers/caregivers served by the HANDS program with children aged 6 months who report having a medical home. Improvement will be indicated by an increase in the proportion of HANDS participants reporting a medical home compared to the baseline.

Data will be obtained through the HANDS database, which collects information on whether or not the mother/caregiver has a medical home on the Family Status Worksheet. The worksheets are completed by Family Support Workers who are trained to collect this data through personal interviews with the families. The responses will include Yes, No, and Unknown.

Analysis will be conducted using SAS version 9.2. Any unknown or missing values will be excluded from analysis and data will be summarized using frequencies and percentages reported

in aggregate form and broken down by county of residence, maternal age, race, and payor source for delivery. Data will be reported as the percentage of mothers/caregivers enrolled in the HANDS program who report having a medical home.

Construct: Inter-birth Intervals

Improvement in inter-birth intervals will be an increase in the proportion of women with prenatal entry in the HANDS program with an inter-pregnancy interval greater than or equal to 18 months compared to the baseline.
Live birth certificate files from the Office of Vital Statistics linked with HANDS program data will be the primary data source for measuring the construct. The live birth certificate includes the date of the last birth/date of last other pregnancy outcome and the date of the last menstrual periods. The inter-birth interval is calculated as the difference in months between the two dates. The data are collected by the birthing facility and are thought to be reliable and accurate.

Data will be analyzed using SAS version 9.2. The number of months between pregnancies will be calculated as the difference between the date of the last menstrual period and the date of the last birth/other pregnancy outcome. These values will be dichotomized into two groups: inter-birth intervals less than 18 months and inter-birth intervals greater than or equal to 18 months. Missing or unknown values will be excluded. The data will be analyzed in aggregate and broken down by county of service, maternal age, and race. Data will be reported as the percentage of women participating in HANDS with inter-birth intervals greater than or equal to 18 months

Construct: Screening for Maternal Depressive Symptoms

Maternal depression will be assessed by determining whether a mother has a history of depression and/or is depressed at the time of screening. Women who screen positive will be referred to medical professionals. Improvement will be measured by an increase in the proportion of referrals to medical professionals for depressed women and a subsequent decrease in repeat positive depression screens for women previously treated.

Data will be collected by the HANDS program via three methods. The HANDS referral documentation determines a history of depression in the women screened. Women are screened using the Edinburgh Postnatal Depression Scale at the time of enrollment in the program and at up to four times during enrollment in HANDS. HANDS also collects data at the end of the depression screen on whether a referral was utilized, and why a referral was not given if screening is positive and a referral was not utilized. Data are self-reported to HANDS home visiting staff and are subject to recall, social desirability, and interviewer biases. The Edinburgh Postnatal Depression Screening is highly specific and sensitive and has been validated by empirical testing methods. All HANDS personnel who administer the screening are nurses, social workers, or other healthcare professionals and have been trained by HANDS in screening methods. Based on the Edinburgh scale, a score of 13 or more indicates current depressive symptoms and results in a referral to a healthcare provider.

HANDS caseworkers will review documents to determine whether a woman has been screened for depression and what her status is in order to inform their visits. Maternal depression data will

be used to calculate the proportion of HANDS women with histories of depression, the proportion of depressive women not receiving services for depression, the proportion of women who received services for depression due to HANDS referrals, and the referral outcome proportions. Data will be reported as the percentage of women enrolled in HANDS screening positive for depression who are referred to medical professionals and the proportion of women previously treated for depression who have repeat positive depressive screens.

Construct: Breastfeeding

This construct will be used to measure the proportion of mothers served by the HANDS program prenatally who breastfeed their infants at six months of age. Improvement will be indicated by a higher proportion of women with prenatal care entry in the HANDS program who breastfeed their children at six months compared to the baseline.

The HANDS database collects information regarding breastfeeding on the Family Status Worksheet obtained by a Family Support Worker who is trained to collect sensitive data. The data are collected as a yes/no variable with any women reporting breastfeeding at six months classified as a yes, and women reporting not breastfeeding at six months a no. Unknown or missing values will be excluded from the analysis.

Analyses will be conducted using SAS 9.2. The proportion of HANDS participants breastfeeding at six months will be summarized using frequencies and percentages. Data will be analyzed in aggregate as well as stratified by race, maternal age, payor source, and county in order to target various groups for interventions. The data will be reported by the percent of HANDS mothers breastfeeding at six months postpartum.

Construct: Well Child Visits

This construct will be used to measure the proportion of children aged one year served by the HANDS program who receive the recommended schedule of well child visits. Improvement will be measured by a higher proportion of children receiving the recommended schedule of visits compared to the baseline.

Maintenance of well child visit schedules is collected by the Family Status Worksheet in the HANDS database. This data is collected by the Family Support Worker, who is educated in collecting this information. The data are obtained by personal interview with the family and by review of documentation from the provider that a health care visit occurred. HANDS uses a Health Progress form to document the date and any notes of a well child visit at age one month, two months, four months, six months, nine months, one year, 15 months, 18 months, and two years. The home visitor verifies this information as proof that documentation has been reviewed. At the one year home visit a review of the Health Progress form is completed to determine whether the six visits have occurred. If all six visits occurred the child is said to have completed the recommended schedule of well child visits.

Data will be analyzed using SAS version 9.2. The data will be reported as percent of children participating in HANDS who received the recommended number of well child visits at one year

of age. Data will be summarized using frequencies and percents and will be analyzed in aggregate and stratified by county of service.

Construct: Maternal and Child Health Insurance

Objectives:

1. Increase the proportion of mothers served by the HANDS program who report insurance coverage on entry into the program.
2. Increase the proportion of children exiting the HANDS program who have insurance coverage.

Improvement will be indicated by a higher proportion of mothers entering the program with health insurance and a higher proportion of children exiting the program with insurance coverage compared to baseline levels.

The HANDS database collects information on whether or not the mother/caregiver and/or the child have insurance coverage on the Family Status Worksheet. The information is obtained by personal interview conducted by a Family Support Worker. The responses for this variable are: Medicaid, private insurance, or uninsured.

The data will be dichotomized into two categories: insured and uninsured. The insured group will include participants who have private insurance or Medicaid, and those reporting they are uninsured will comprise the uninsured group. Unknown or missing values will be excluded from the analysis. Analyses will be completed with SAS version 9.2. Data will be reported as the percentage of mothers/caregivers served by HANDS who have insurance coverage at the time of entry into the program. Data will also be reported as the percentage of children who have insurance coverage at the time of exit from the HANDS program.

II. Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits

Data will be obtained through multiple sources. Data for emergency department (ED) visits for both mothers and children and incidence of child injuries requiring medical treatment will be obtained through the Kentucky Department for Medicaid Services, which will track ED visits for Medicaid-eligible children enrolled in the HANDS program. More than 90% of HANDS participants are Medicaid recipients in Kentucky. The Kentucky ED electronic record database doesn't have personal identifiers and HANDS participants cannot be identified directly from the database. Data on reported suspected maltreatment for children, reported substantiated maltreatment, and first-time victims of maltreatment of children will be obtained by the Department for Community Based Services, Division of Child Protection and Safety. All reports are collected in the TWIST database system, which includes case reports, medical evaluations, family histories, and social worker comments. All other data will be collected from surveys administered by HANDS program personnel to adult participants.

Data will be monitored continually and a report will be produced annually.

Construct: Child Visits to Emergency Departments from All Causes

Improvement will be indicated by a decrease in the rate of ED visits for children enrolled in the HANDS program. ED visit rates will be compared with the rate of visits for a group of children who were eligible for the program but did not participate.

Data will be obtained through the Kentucky Department for Medicaid Services' database. 90% of HANDS participants are enrolled in Medicaid. The rate will be calculated as the total number of ED visits billed to Medicaid divided by the total number of children enrolled. Children who are not enrolled in Medicaid will be excluded in the calculation of this indicator. Medicaid data are routinely checked to provide accurate quality data.

Analyses will be conducted in SAS 9.2 and the data will be summarized by aggregate data as well as stratified by age group. Data will be reported as a decrease in the number of Medicaid-eligible children enrolled in HANDS who have visited the ED compared to baseline levels. Reports will be generated annually.

Construct: Mother visits to Emergency Departments from All Causes

Improvement in the construct will be characterized by a decrease in the rate of ED visits for mothers enrolled in the HANDS program. ED visit rates for HANDS mothers will be compared to the rate for mothers who were eligible but did not participate in the program.

Data will be obtained through the Kentucky Department for Medicaid Services' database. 90% of HANDS mothers are enrolled in Medicaid. The rate will be calculated as the total number of ED visits billed to Medicaid divided by the total number of women/caregivers enrolled. Women/caregivers who are not enrolled in Medicaid will be excluded in the calculation of this indicator. Medicaid data are routinely checked to provide accurate quality data.

Analyses will be conducted in SAS 9.2 and data will be summarized by aggregate. Data will be reported as a decrease in the number of Medicaid-eligible women enrolled in HANDS who have visited the ED compared with baseline levels. Reports will be generated annually.

Construct: Information Provided or Training of Participants on Prevention of Child Injuries

Improvement of the construct will be quantified by an increase in the number of HANDS adult participants who received information and were trained on the prevention of childhood injuries. Data will be collected by surveys administered by HANDS personnel. Adult participation surveys provide the most comprehensive data in this area as training and information can come from a variety of sources and only the participant can report this data. The data will be collected quarterly with the first survey administered upon entry to the program.

Analyses will be conducted using SAS version 9.2. The construct will be reported as the percentage of HANDS participants who receive information or training on injury prevention by the total number of families participating. Data will be evaluated for improvements in the

number of HANDS participants who receive information or training on childhood injury prevention.

Construct: Incidence of Child Injuries Requiring Medical Treatment

Improvement in this area will be constituted by a decrease in the rate of child injuries requiring medical treatment in HANDS participants. The rate of child injuries in HANDS participants will be compared with a control group that was eligible for HANDS but did not participate.
Data will be collected through the Medicaid Services' database. The Kentucky ED and inpatient hospital discharge records do not have personal identifiers and HANDS participants cannot be identified directly from these databases; more than 90% of HANDS participants are Medicaid recipients. Medicaid claims data are high quality due to the high number of quality checks performed on the data. Medically treated injuries for both children enrolled in HANDS and those in the control group will be identified through this system. Injury cases will be identified as cases with principal diagnosis codes of injury. Children who are not Medicaid recipients will be excluded from this construct as there are not appropriate measures to identify them through hospital databases.

Data will be reported by aggregate numbers, and stratified by age group. It will be reported as the rate of child injuries requiring medical treatment in HANDS participants. The rate will be calculated as the total number of injuries treated in hospitals, ED, and ambulatory care billed to Medicaid divided by the total number of children.

Construct: Reported Suspected Maltreatment for Children in the HANDS Program

This construct will be measured as the number of cases of suspected maltreatment divided by the total number of children in the HANDS program. Improvement will be quantified as a decrease in the number of children who have been referred to the Department for Community Based Services (DCBS) for suspected maltreatment.

Data will be collected by the Department for Community Based Services, Division of Child Protection and Safety. All reports of both suspected and substantiated maltreatment are maintained in the TWIST database, which includes case reports, medical evaluations, family histories, and social worker comments. This data are collected and entered by trained nurses and social workers and is routinely updated and is housed on a secure server. HANDS data will be linked with TWIST data to determine how many HANDS children have a report of suspected maltreatment. It is possible that an increase in reports for suspected maltreatment will be observed in this population due to the nature of the families the HANDS program serves. All families receiving HANDS services are monitored for reports of child maltreatment.
For the analysis, HANDS data will be linked with DCBS data on suspected maltreatment. Frequencies and rates of suspected maltreatment will be calculated and compared to the benchmark. Data will be reported in aggregate and stratified by age group as well as maltreatment type. Data will be reported annually as the rate of suspected cases of maltreatment in HANDS children.

Construct: Reported Substantiated Maltreatment for Children in the HANDS Program

This construct will be measured as the number of cases of substantiated maltreatment divided by the total number of children in the HANDS program. Improvement will be quantified as a decrease in the number of children who have been referred to the Department for Community Based Services (DCBS) for substantiated maltreatment.

Data will be collected by the Department for Community Based Services, Division of Child Protection and Safety. All reports of both suspected and substantiated maltreatment are maintained in the TWIST database, which includes case reports, medical evaluations, family histories, and social worker comments. This data are collected and entered by trained nurses and social workers and is routinely updated and is housed on a secure server. HANDS data will be linked with TWIST data to determine how many HANDS children have a report of suspected maltreatment. It is possible that an increase in reports for substantiated maltreatment will be observed in this population due to the nature of the families the HANDS program serves. All families receiving HANDS services are monitored for reports of child maltreatment.

For the analysis, HANDS data will be linked with DCBS data on substantiated maltreatment. Frequencies and rates of substantiated maltreatment will be calculated and compared to the benchmark. Data will be reported in aggregate and stratified by age group as well as maltreatment type. Data will be reported annually as the rate of substantiated cases of maltreatment in HANDS children.

Construct: First-time Victims of Maltreatment for Children in the HANDS Program

Improvement in this construct will be indicated by a decrease in the number of children enrolled in HANDS who are reported to DCBS for suspected maltreatment and are first time victims. This measure will be calculated by the number of children who are first-time victims divided by the number of children in the program. First-time victims are those who have a maltreatment disposition of "victim" and have never had a prior case.

Data will be collected by the Department for Community Based Services, Division of Child Protection and Safety. All reports of both suspected and substantiated maltreatment are maintained in the TWIST database, which includes case reports, medical evaluations, family histories, and social worker comments. This data are collected and entered by trained nurses and social workers and is routinely updated and is housed on a secure server. HANDS data will be linked with TWIST data to determine how many HANDS children have a report of suspected maltreatment. It is possible that an increase in reports for suspected maltreatment will be observed in this population due to the nature of the families the HANDS program serves. All families receiving HANDS services are monitored for reports of child maltreatment.
For the analysis, HANDS data will be linked with DCBS data on first-time victims of maltreatment. Frequencies and rates of substantiated maltreatment will be calculated and compared to the benchmark. Data will be reported in aggregate and stratified by age group as well as maltreatment type. Data will be reported annually as the rate of first-time victims of maltreatment in HANDS children.

III. Improvements in School Readiness and Achievement

Data will be obtained from the HANDS database The HANDS database is collected electronically on an ongoing basis. Analyses using these data will be completed on a quarterly basis. Comprehensive reports will be completed annually.

Data will be collected using the Family Rating Scale, the Ages and stages Questionnaire (ASQ), and the HANDS database. The Family Rating Scale is used to determine parenting skills, beliefs, and resources in order to ensure support for child development. The ASQ collects information about the child's communication, gross motor, fine motor, problem solving, personal-social, and social-emotional scores. The following question from the Family Rating Scale will be used:

1. Provides enriching/learning experiences.
2. Understands child development

Parents are evaluated for parental behaviors and resources when their child is one month old by a Family Support Worker who is trained to collect data. The data are collected through personal interviews with the parent/caregiver as a scale variable at one month and one year of age. Parents who improve on the scale between screenings will be grouped as improved, all other parents will be coded no improvement. Unknown or missing values will be excluded from the analysis.
Data for the following constructs will be collected using the Family Rating Scale: parent support for children's learning and development, parent knowledge of child development and of their child's developmental progress. Data for child's communication, language, and emergent literacy, child's general cognitive skills, child's positive approaches to learning including attention, child's social behavior, emotional regulation, and emotional well-being will be collected using the ASQ. The HANDS database contains data relating to depression history, history of substance use, domestic violence, and employment status, which are factors that quantify parent emotional well-being or parenting stress. Parenting behaviors may be observed during HANDS personnel visits and recorded in the system.

Improvements will be quantified as an increase in number of parents/children who showed an increase on the scale for the measure. Rates will also be calculated based on number of parents and/or children who show improvement divided by the total number of HANDS participants in the respective groupings.

Data will be analyzed using SAS version 9.2. Frequencies and percents will be used to summarize the data. Data will be analyzed in aggregate and by county of service, maternal age, race, and payor source for delivery.

IV. Crime or Domestic Violence

Data will be obtained through the HANDS database. The database is collected electronically on an ongoing basis. Data are collected up to three times: 6-8 months prenatal, 2-8 weeks postpartum, and 8-12 months postpartum. Comprehensive reports will be completed annually.

Construct: Screening for Domestic Violence

Improvement in this construct will be measured by an increase in the rate of domestic violence screenings among HANDS women over time compared to the baseline. In addition, a decrease in the rate of domestic violence will be considered an improvement.

The physically Hurt, Insulted, Threatened with harm, and Screamed (HITS) Domestic Violence Screening Scaled will be used to identify intimate partner violence. The screening tool is quick to administer and is reliable and valid. The data will be collected by HANDS personnel who are trained in screening methods. The data will be used to determine characteristics of HANDS participants who are victims of domestic violence (i.e. Medicaid status, depression history, number of children, age of mother, etc.) all of which are collected in the HANDS database. The data will be collected as a scale variable with scores greater than 10 considered positive screens for domestic violence. The variable will be dichotomized based on this cut-point for analysis. Data will be reported as frequencies and percents and will be presented in aggregate. Missing or unknown values will be excluded from analysis. To determine improvement in screening the number of HANDS participants completing the HITS screening will be divided by total HANDS participants. An increase will indicate improvement in that area. To determine improvement in the rate of domestic violence, the number of women who screened positive for domestic violence will be divided by the total number of HANDS participants. A decrease in the rate compared to baseline will be considered improvement.

Construct: Of Families Identified for the Presence of Domestic Violence, Number of Referrals Made to Relevant Domestic Violence Services

Improvement in this construct will be measured by an increase in the rate of referrals made to women who screened positive for domestic violence over time.
The physically Hurt, Insulted, Threatened with harm, and Screamed (HITS) Domestic Violence Screening Scaled will be used to identify intimate partner violence. The screening tool is quick to administer and is reliable and valid. The data will be collected by HANDS personnel who are trained in screening methods. The data will be collected as a scale variable with scores greater than 10 considered positive screens for domestic violence. Scores greater than 10 indicate that a referral is needed an appropriate services should be identified.

HANDS caseworkers will review documents to determine whether a woman has been screened for domestic violence and what her status is in order to inform their visits. Domestic violence data will be used to calculate the proportion of HANDS women with histories of domestic violence, the proportion of domestic violence cases not receiving services, the proportion of women who received services for domestic violence due to HANDS referrals, and the referral outcome proportions. Data will be reported as the percentage of women enrolled in HANDS screening positive for domestic violence who are referred to professionals and the proportion of women previously screened for domestic violence who have repeat positive domestic violence screens.

Data will be reported as a rate of appropriate services identified and referrals made divided by the total number of participants with positive domestic violence screens. Improvement will be indicated by an increase in this rate compared to baseline values.

Construct: of Families Identified for the Presence of Domestic Violence, Number of Families for Which a Safety Plan was Completed

Improvement in this construct will be measured by an increase in the rate of safety plans made to women who screened positive for domestic violence over time.
The physically Hurt, Insulted, Threatened with harm, and Screamed (HITS) Domestic Violence Screening Scaled will be used to identify intimate partner violence. The screening tool is quick to administer and is reliable and valid. The data will be collected by HANDS personnel who are trained in screening methods. The data will be collected as a scale variable with scores greater than 10 considered positive screens for domestic violence. Scores greater than 10 indicate that a referral is needed and safety plans should be developed.

HANDS caseworkers will review documents to determine whether a woman has been screened for domestic violence and what her status is in order to inform their visits. Domestic violence data will be used to calculate the proportion of HANDS women with histories of domestic violence, the proportion of domestic violence cases not receiving services, the proportion of women who received services for domestic violence due to HANDS referrals, and the referral outcome proportions. Data will be reported as the percentage of women enrolled in HANDS screening positive for domestic violence who are referred to professionals and the proportion of women previously screened for domestic violence who have repeat positive domestic violence screens. HANDS workers will work with the victims to develop a safety plan.

Data will be reported as a rate of safety plans made divided by the total number of participants with positive domestic violence screens. Improvement will be indicated by an increase in this rate compared to baseline values.

V. Family Economic Self-Sufficiency

Data will be obtained through the HANDS database. Information is updated electronically in an on-going basis. Comprehensive reports will be produced annually.

Construct: Household Income and Benefits

Improvement in this construct will be quantified as an increase in total household income and benefits over time.

Data on income and benefits are collected by HANDS personnel upon entry into the program, and is updated one year later. An increase in income and benefits between the two measurements is considered an improvement. Data are based on parent/caregiver self-report to HANDS program personnel and are subject to reporting bias. Data will be dichotomized to allow for analysis: increases in income and benefits will be given a value of yes, and decreases or no change will be given values of no.

Data will be reported as a rate of increase in income and benefits over time. It will be calculated as total families who increased income and benefits over total HANDS participants. Increases in the rate will be considered improvement over time.

Construct: Employment or Education of Adult Members of the Household

Improvement in this construct will be indicated by an increase in the educational attainment of adult HANDS participants over time. Improvement will also be indicated by an increase in the number of adult participants who are employed over time.

The data will be collected by HANDS personnel during entry to the program and one year later. Data on education level and employment status are collected and maintained in the HANDS database. Data will be based upon self-report and are subject to reporting bias. Data for employment will be recorded as the number of adult household members employed during the month and average hours per month worked. Education will be measured by educational benchmarks achieved by each adult household member. HANDS staff will work with families to improve these measures through referrals, linkage, and encouragement.

Data will be reported as the rate of employment among HANDS participants: number of HANDS participants who are employed over total number of participants. And will be compared to baseline. Education will be reported as a rate of increased educational attainment over time. When more benchmarks have been achieved it indicates an improvement in education.

Construct: Health Insurance Status

Objectives:

1. Increase the proportion of mothers served by the HANDS program who report insurance coverage on entry into the program.
2. Increase the proportion of children exiting the HANDS program who have insurance coverage.

Improvement will be indicated by a higher proportion of mothers entering the program with health insurance and a higher proportion of children exiting the program with insurance coverage compared to baseline levels.

The HANDS database collects information on whether or not the mother/caregiver and/or the child have insurance coverage on the Family Status Worksheet. The information is obtained by personal interview conducted by a Family Support Worker. The responses for this variable are: Medicaid, private insurance, or uninsured.

The data will be dichotomized into two categories: insured and uninsured. The insured group will include participants who have private insurance or Medicaid, and those reporting they are uninsured will comprise the uninsured group. Unknown or missing values will be excluded from the analysis. Analyses will be completed with SAS version 9.2. Data will be reported as the percentage of mothers/caregivers served by HANDS who have insurance coverage at the time of entry into the program. Data will also be reported as the percentage of children who have insurance coverage at the time of exit from the HANDS program.

VI. Coordination and Referrals for Other Community Resources and Supports

Data will be obtained through the HANDS database. Information is updated electronically in an on-going basis. HANDS personnel conducting interviews to obtain data are trained to collect each measure. Comprehensive reports will be produced annually.

Construct: Number of Families Identified for Necessary Services

Improvement in this area will be measured as an increase in screenings for various services compared to baseline values. Screenings will be performed in four areas: maternal depression, domestic violence, developmental delays in children, and social-emotional concerns in children. Data will be obtained through the HANDS database which collects information in all four areas by Family Service Workers who conduct personal interviews with HANDS participants. Data for depression is screened using the Edinburgh Depression Screen, domestic violence is screened using the HITS screening tool, and the Family Status Worksheet collects information on developmental delays and social-emotional concerns in children using the Ages and Stages Questionnaire. All screening tools are deemed reliable in measuring the appropriate construct and collecting valid data. Data on depression and domestic violence will be collected from all women enrolled in the HANDS program in the prenatal period and at two intervals postnatal. Data on childhood developmental delays and social-emotional concerns will be collected at one month and one year of age.

Analyses of the data will be performed using SAS version 9.2. Data for each screening will be summarized using frequencies and percentages and will be displayed in aggregate and stratified by county of service, maternal age, race, and age group (for children). Rates for screenings will be determined by the number of screenings conducted for each of the chosen areas over the total number of HANDS participants. Data will be reported as an increase in screenings for necessary services over time.

Construct: Number of Families that Required Services and Received a Referral to Available Community Resources

Improvements in this construct will be quantified by an increase in the number of referrals made to families that screened positive for depression, domestic violence, developmental delays, and social-emotional concerns, when services are available in the community.

Screening tools will be used to determine whether families require services in the above areas. HANDS caseworkers will review documents to determine whether a woman has been screened for depression and domestic violence and whether a child has been screened for developmental delays and social-emotional concerns and what the status is in order to inform their visits. The HANDS database collects information on whether or not referrals were made for women/children screening positive. Positive screens include >10 for domestic violence, ≥12 for depression, <48 for social-emotional concerns, and scores in the following areas for developmental delays: <15.8 in communication, <18 in gross motor, <28.4 in fine motor, <25.2 in problem solving, and <20.1 in personal-social. The proportion of HANDS participants screening positive will be matched with data on referrals. Data will be used to calculate the proportion of participants not receiving services, the proportion who received services due to referrals, and the proportion of referral outcomes.

Data will be reported as the proportion of families screening positive for the problem who receive a referral over the total number of participants. Data will be reported in aggregate and stratified by county of service and age group (for children).

Construct: MOU's

Improvement in this construct will be indicated by an increase in the number of formal agreements with social service agencies.
Data will be collected via the HANDS database. All MOU's in place with the HANDS program are kept on file in the central office and updated regularly.
Data will be reported as the total number of social service agencies with an MOU and/or regular communication with the HANDS program.

Construct: Information Sharing

Improvement in this construct will be indicated by an increase in the number of social service agencies that engage in regular communication with the home visiting provider.
Data are collected on the HANDS database which is updated regularly. The database contains a service list with corresponding points of contact for each agency. The HANDS program will work with other agencies in order to ensure appropriate referrals are made and points of contact are added to the contact list.

Data will be reported as the number of agencies with which there is a clear point of contact and regularly shares data with the HANDS program.

Construct: Number of Completed Referrals

Improvement in this construct is indicated by an increase in the percentage of families with referrals for which receipt of services can be confirmed.

Data will be obtained through the HANDS database, which contains all information collected on participants. Referral lists are kept on file for each family and are updated regularly. Follow-up visits for families receiving referrals are administered at subsequent home visits and are verified through contact with the referred agency on a monthly basis.

Data will be reported as the proportion of referrals of participating families with identified needs whose receipt of service was verified over the total number of participating families with identified needs.

ORGANIZATIONAL INFORMATION

HANDS is within the Kentucky Cabinet for Health and Family Services (CHFS), which is home to most of the state's human services and health care programs, including Medicaid, the Department of Community Based Services (DCBS), and the Department for Public Health (DPH) *(See Attachment 5: Organization Chart)*. As part of the Cabinet, HANDS is under the

oversight of the Department for Public Health, within the Division for Maternal and Child Health, Early Childhood Development Branch. The Department of Public Health develops and operates all public health programs and activities for the citizens of Kentucky including health service programs for the prevention, detection, care and treatment of physical disabilities, illness and disease. The Division of Maternal and Child Health's mission is to provide leadership, in partnership with key stakeholders, to improve the physical, socio-emotional health, safety and well-being of all Kentucky women, infants, children, adolescents and their families. The Early Childhood Development Branch provides active leadership in achieving the health goals of the state's early childhood initiatives through HANDS, Child Care Health Consultation for Healthy Start in child Care, Early Childhood Mental Health, First Steps: Kentucky's Early Intervention System, Newborn Metabolic Screening and KY Birth Surveillance Registry.

In addition to being a part of the CHFS's structure, HANDS has a 10 year, well established collaboration with other early childhood programs and systems through our KIDS NOW Initiative (housed in the Cabinet for Education and Workforce Development, Department of Education, Division of Early Childhood). Through the KIDS NOW Initiative 25% of Kentucky's Master Tobacco Settlement dollars go to early childhood programs across departments and cabinets, including mental health, child care, public health, and education. The funding and programs have been coordinated by the Early Childhood Development Authority, which facilitates true collaboration of programs through a quarterly meeting where representatives of the funded programs meet to share about their programs and develop a quarterly report of activities. This is the group that oversees the state's system of Community Early Childhood Councils. The Authority is currently being revised to become the State Early Childhood Council of the Head Start Reauthorization Act. Through the committed leadership of all the state agencies who have programs addressing maternal and infant and early childhood health, development, and well-being, Kentucky remains committed to the coordination of early childhood programs throughout the state, regardless of what agency administers them.

The MIECHV Program will be directly managed by the staff of the current state-wide HANDS home visiting program. At the state Central Office staff consists of a Program Administrator, Quality Assurance (QA) Coordinator, Technical Assistance (TA) Coordinator, Training Coordinator, Data Coordinator, federal Grant Administrator and Administrative Assistant. The Program Administrator is responsible for oversight of all aspects of the program (TA, training, data collection / reporting and evaluation), with emphasis on the regulations, finances, policies and procedures, human resource activities, and collaboration with other state/federal agencies.

The TA Coordinator monitors the activities of the TA Team, which is comprised of seven (7) regional staff. She tracks the completion of all components involved in all annual site visits, which are performed to analyze the quality of home visitation services being provided. This includes tracking of TA schedules, as well as documentation and follow-up of TAs and sites in regards to the results found during each site visit. She also facilitates monthly TA Team meetings which focus on information sharing and exchange between the Central Office team and the TA Team. Agendas focus on allocation of funds, review of monthly data reports, updates to training schedules/practices/concerns, TA specific questions/concerns/recommendations based on interactions with program staff within their assigned region, and TA team/individual goal setting/skill development/successes. She coordinates the development of resource materials TAs

utilize when giving support to sites. She will provide technical assistance to and monitoring of those counties that implement the expansion to multigravida families, as identified for the MIECHV Program, and will assist the Federal Program Administrator in collaboration efforts with other early childhood programs.

The TA team consists of members who have had prior experience in the HANDS program (HANDS Coordinator / Supervisor) and have successfully completed three weeks of intensive training designed for the initial skill development of a new TA. The role of each TA is to assess the fidelity of program implementation by conducting at least one annual visit per assigned site. Through interviewing, shadowing of staff, chart reviews, and data report analysis TAs gather information for completion and data entry of the *HANDS Program Standards Checklist: TA Site Visit and Site Self Assessment Document,* which examines the following program components: referral screening, family assessment, staff supervision, community collaboration, staff training, utilization of curriculum, administration of a developmental screening tool, service referrals, program management, completion of all documentation, and data entry into the web based system. Based on the findings of the "checklist," a summary identifying site specific strengths and opportunities for growth is completed and shared with the site. The site then develops a plan for growth to identify strategies and activities they will perform in order to meet program standards outlined as opportunities for growth. Beginning in fiscal year 2011, "checklist" results have been entered into the web based data system to serve as a baseline for future tracking of each sites progress in meeting program standards, as well as outlining targets for desired compliance. Information gathered at the annual site visit, in conjunction with feedback obtained by TAs during additional site visits and phone / email contact, is beneficial to identifying program practices that require further refinement or program practices that may be duplicated across sites to improve home visitation services.

The QA Coordinator reviews various sources of information (data reports, surveys, observations, etc) to examine the fidelity of program implementation and coordinates activities which are deemed beneficial for continuous quality improvement. These activities currently include maintenance of the *HANDS Program Standards Checklist: TA Site Visit and Site Self Assessment Document* (described above) and analysis of results reported on this instrument. In addition, the QA Coordinator facilitates distribution and analysis of annual *HANDS Parent Satisfaction Surveys* and *HANDS Site Satisfaction Surveys*. The *HANDS Parent Satisfaction Survey* is distributed to participants who have actively received services during the previous six (6) months and those who have been exited from the program over the past twelve (12) months. The survey gathers information from the families in regards to the quality, duration, frequency, and impact of services provided to each family. The results are then entered into the HANDS web based data system and a statewide summary report is developed. The *HANDS Site Satisfaction Survey* is distributed to each HANDS site to gain input from program staff about the frequency and benefits of support received from TA services; the value of training opportunities; those areas of program implementation that require additional support; and the receipt/benefit of HANDS materials (brochures, posters, and *Helping HANDS for Healthy Home* resources) and results are reported as an average of each staff person's rating. These results are also reported into the HANDS web based data system and reports can be accessed to summarize statewide results, results per site and results per TA region. As information is analyzed, the QA Coordinator works with other HANDS staff to determine if enhancements or the development of

new policies, practices, trainings, methods of documentation, etc. are recommended. She then coordinates the steps and activities to address the identified enhancements/developments. This adds another layer to examining the fidelity of program implementation.

The Training Coordinator is responsible for overseeing implementation of the skill development framework put into place for HANDS staff. This Coordinator works with a team of trainer, facilitating the logistics and evaluation of the core, curriculum, and advanced trainings they provide. In addition, she grants approval of trainings offered outside the HANDS structure when the opportunities meets a specific set of learning objectives within identified topic areas (Supervision, Program Evaluation, Collaboration, Program Development, Program Management, Program Orientation & Community Resources, Child Abuse & Neglect/CPS Referral or Reporting, Problem Solving/Crisis Referrals, Confidentiality & Ethics, CPR/First Aid, Home Visiting Safety, Domestic Violence, Substance Abuse, Mental Health Issues, Developmental Screening, Values Clarification/Cultural Competency, Prenatal Care, Postpartum Care, Communication Skills, Language Development, Working with Fathers, Temperament & Discipline, Dealing with Loss, Stress & Time Management). She is the lead for planning a two-day, bi-annual training academy which provides HANDS staff across the state with the opportunity to obtain their required training and to re-energize.

Since the TA Team monitors each site's ability to apply training into practice, communication between the Training Team and the TA Team is essential; therefore, this Coordinator participates in the TA monthly meetings and acts as a liaison between the two groups. Quarterly Training Team meetings are facilitated by this Coordinator to address any trainer questions / concerns / recommendations for refinement of training that may arise. In addition to coordinating communication between the TA and Training teams, the Training Coordinator handles arrangements for quarterly HANDS Coordinator meetings which provide a venue for statewide communication in regards to program performance, updates, concerns, skill development, etc.

The Training Team consists of trainers who have been certified by Growing Kids, Inc. to provide required trainings to HANDS staff. Each trainer's certification represents his/her extensive training and knowledge acquisition in a core area (Screening and Assessment, Home Visitation, Growing Great Kids curriculum, etc.). Since training of all staff engaging in home visitation and supervision is key to program success, there is required training for all staff serving in the HANDS program. Trainings occur in the following sequence that enables staff to transfer knowledge into practice: Core Training (Parent Visitor & Family Support Worker), Growing Great Kids Curriculum Training, Advanced Trainings, and Wraparound / Basic Training. Completion of Core training modules provides staff with the foundational knowledge needed to perform their specific role. This knowledge is integrated and anchored into Growing Great Kids Curriculum trainings, which provides staff with a guide to providing quality home visits that foster positive pregnancy outcomes, parent-child interactions, child growth and development, healthy and safe homes, and family decision-making / self-sufficiency. To maintain program effectiveness, staff must maintain and expand upon existing skills. Opportunities to continue growth and development of skills are provided through supervision, advanced and wraparound training components.

The Data Coordinator works closely with web developers, assigned to HANDS by the Cabinet, to continually adapt an existing web based system designed to gather "real time" data essential to

the analysis of program effectiveness and needs. The data system can be accessed and reports generated at all levels, with feedback providing insight into how effective the program is and what opportunities for growth exist. As program opportunities are identified, the Data Coordinator works with the web developers to update/change the web based system to monitor future successes and opportunities. She also provides technical support to HANDS data entry staff, as well as members of the Central Office, TAs, Trainers, Coordinators, and Supervisors. Support primarily focuses on how to enter data so information is accurate and relevant to the targeted outcomes, as well as support in extracting data reports that are meaningful and useful to monitoring and identifying program strengths and opportunities for growth.
In order to build upon the existing functions of the Central Office and to successfully implement the MIECHV grant, a federal Program Administrator and Epidemiologist have been added to the Central Office staff structure. The federal Program Administrator will oversee all responsibilities of the ACA grant. She will plan, develop and implement a process for enhancing home visitation in the selected at-risk communities. In addition, she will monitor and track new program reports, develop monthly reports, and coordinate home visiting program and needs assessments across early childhood programs such as Title V, CAPTA, etc. She will also compile and submit data and required reports to federal and state authorities.

The Epidemiologist will collect, analyze, interpret and report on data pertaining to home visitation. She will collaborate in planning, implementing and support of statewide home visitation program databases for MCH, as well as prepare reports, charts, graphs and presentations to assist with analysis of data. She is instrumental in the formation of hypothesis to explain data and improve overall data system for Maternal and Child Health, and analysis of data for benchmark monitoring.

An Administrative Assistant provides clerical support to the HANDS Central Office team. She is primarily responsible for directing communications to appropriate staff, distributing public relations materials to sites and other agencies across the state, and sharing statewide communications with sites when needed. She also plays an important role in completion of the HANDS monthly service reports.

In addition to the HANDS Central Office, there are currently over 500 staff trained to provide home visiting services across Kentucky. Each HANDS program is housed in one of Kentucky's district or independent Health Department sites and has HANDS staff responsible for the roles of Parent Visitor (family assessment), Family Support Worker (home visitation), RN/SW (quarterly home visits to provide a health/medical perspective), Data Entry Clerk (entry of required data that is reflective of service delivery), Supervisor (face-to-face supervision, shadowing, and monitoring of HANDS staff), and Coordinator (oversight of local HANDS program). All HANDS staff are under the administrative direction of a Health Department Director / Administrator, who oversees all programs implemented by the Health Department.

The Health Department staff are the direct line to families, beginning with the screening and assessment process of expectant/new/multigravida parents. Families are screened by anyone trained (including community partners) to utilize the nationally proven tool that has been selected to briefly examine identified risk factors. When families screen positive they are referred to the HANDS program for further assessment (Parent Survey/Kempe) by the Parent

Visitor to determine if they would benefit most from referrals to community resources and / or participation in intensive home visitation services from HANDS. If HANDS home visitation is offered to and accepted by a family, a Family Support Worker engages the family in weekly home visits designed to target HANDS program goals: positive pregnancy outcomes, optimal child growth and development, children living in healthy / safe homes, and families who are self-sufficient. Visits are planned utilizing the *Growing Great Kids Curriculum,* as well as completion of family goals, a childproofing checklist, child and family rating scale, *Ages and Stages* developmental screenings, and the *Edinburgh Depression Screen.* In addition to weekly home visits, families receive quarterly RN/SW visits to support the family with health and medical focuses (i.e., well-child checks, immunizations, second-hand smoke, drug abuse, etc.).

All services are documented and information entered into the HANDS web based data system by the Data Entry Clerk. Accurate and timely data entry provides the HANDS staff with the information they need to perform their job responsibilities. In addition to the Supervisor and Coordinator, the Data Clerk also acts as a check-point in regards to the documentation of services.

HANDS depends on supervision for its success. Supervision provides the foundation upon which successful strategies are built to engage families and keep them interested in HANDS. Through regularly scheduled weekly meetings, chart reviews, data report reviews, and shadowing of home visits (Parent Visitor / Family Support Worker / RN-SW) the Supervisor gathers information in regards to the workers strengths and opportunities for growth. Supervision is required weekly for all employees and provides on-going support to discuss caseload weights, engagement strategies, family strengths/concerns, family goals, follow-up plans, use of curriculum, parent-child interaction, staff development, etc. and attention to staff skill development. Supervision is key in the retention of families and delivery of quality services.

The Program Coordinator is responsible for the day-to-day management and oversight of the program. This includes local program planning, budgeting, staffing, training, and program/staff performance evaluations. She (or her designee) is involved in local community collaboration with other programs/agencies. In addition she is responsible for monitoring the quality of services through the implementation of annual parent satisfaction surveys and site satisfaction surveys. She participates in local fund raising, facilitating ongoing collaboration with community/state partnerships and public relations; attends quarterly coordinators meetings; and ensures that staff receive and maintain training requirements.
Since 2003, when HANDS completed roll-out to all 120 counties in the state, Kentucky has continued to build a home visitation program with the mission of building healthy, safe environments for the optimal growth and development of children and the vision of every child being wanted and cared for in a stimulation and nurturing environment. As of March 2011 HANDS staff have collectively provided services to 53,343 families, providing 58,759 assessments and 1,349,485 professional / paraprofessional home visits.

As part of this grant, the Dept for Public Health will also contract with Every Child Succeeds (ECS)/Cincinnati Children's Hospital to train and mentor specialists for the perinatal depression home visiting intervention program enhancement. Specialists will also be monitored by the HANDS TA staff, but will receive discipline specific feedback and monitoring from ECS.

Provide information on the **program's resources and capabilities to support provision of culturally and linguistically competent and health literate services.**

Through the design of and HANDS utilization of the Growing Great Kids curriculum, visits are geared towards being culturally competent. The first five (5) modules of the Growing Great Families component of the curriculum assist the Family Support Worker in learning what is important to the family, so they can be supported in getting what they want from services. The modules focus on parental expectations for their child; family values and strengths; cultural values, traditions and family practices; and creating an individualized plan for family support and growth. Knowing what the family wants and needs is key to building a relationship, therefore HANDS highly encourages sites to engage in these five modules within the first three (3) months of services so visits are planned and facilitated to be culturally competent.

Kentucky has a growing Hispanic population; therefore, curriculum materials, HANDS brochures, HANDS posters, and *Helping HANDS for Healthy Homes* resources are available in Spanish. In addition, Local Health Department staff complete a required training which outlines information in regards to obtaining translation services for non-English speaking clients. A Family Support Worker may be matched to a family because the characteristics she possesses are believed to be compatible with a family.

Describe how the unique needs of target populations of the communities served are routinely assessed and improved. Also describe the organizational capacity of any partnering agencies or organizations involved in the implementation of the project.

HANDS has continually utilized data to assess the successes and areas in need of growth through a variety of resources. This has included the *KIDS* count, HANDS web based data system, monthly reports specific to each health departments implementation of HANDS, epidemiologist z-scores updates, the *HANDS Parent Satisfaction Survey* results, and results of the TA annual visits (utilizing *the HANDS Program Standards Checklist: TA Site Visit and Site Self-Assessment Document*).

Describe the adequacy of resources to continue the proposed project after the grant period ends and the state's demonstrated commitment to home visiting. Provide an assurance that cuts in state funding will not be made to a broad array of home visiting programs in the future.

Kentucky will continue to put forth $8.3 million dollars annually for home visitation services which is the baseline for meeting the Maintenance of Effort as described in the SIR as of March 23rd, 2010. DPH will track expenditures monthly to ensure maintenance of effort.

FY11 Budget

Expense Category	Total Costs
Personnel-Salary and Wage	**$38,760**
Fringe Benefits	**$16,667**
Travel	**$4,786**
Equipment	**$2,500**
Supplies	**$1,500**
Contracts	**$6,898,388**
Other	
Total Direct Charges	**$6,962,601**
Indirect	**$8,527**
Total Requested	**$6,971,128**

Personnel Costs: **$38,760**

The role of Technical Consultant for Healthy Families America will streamline the process of accreditation. This will be a full-time position and the estimated annual salary will be $38,760. The Technical Consultant will serve as a systems coordinator and work with at-risk county and HFA to ensure the standards of the proven home visitation model.

Technical Consultant	X 12 months	$38,760

Fringe Benefits: **$16,667**

The Fringe Benefits will be 43% of the annual salary and they will include FICA, retirement, health insurance, unemployment insurance, life insurance. The fringe benefits are directly proportional to that portion of personnel costs that are allocated for the project.

Technical Consultant	X 12 months	$16,667

Travel: **$4,786**

In State Travel will be necessary to work with the 39 at-risk counties to incorporate a universal screening, collaboration with other home visitation programs and to ensure benchmark data is being completed and HFA standards are achieved.

38 trips X 100 miles @0.47 per mile	$1,786
Out of State Travel to attend required grantee meeting	$3,000

Equipment: **$2,500**

Computers @$2,500 for new staff $2,500

New desktop computer equipment will be necessary for the position that will be created to the current home visiting program.

Supplies: **$1,500**

Supplies X 12 months

Paper, pens	$500
Postage 1,000 letters at .44 ea	$440
Flip Charts, markers, highlighters, binders	$560

Subcontracts: **$6,898,388**

Subcontract: Healthy Families America **$52,388**
Purpose: To join an evidence based model approved through HomVEE
Estimated costs:

- Large site fee: ($1350) x 19 sites = $25,650
- Small site fee: ($675) x 6 sites = $4,050
- Technical assistance site visits: 60% of sites receive review every 4 years @$2,000 per visits = $7,500
- Application Fee: Every four years there is an application fee = $750 (average of $188 per year for four years)
- HFA Evaluation Contract = $15,000

Deliverables:

- Provide technical assistance and on-site evaluation of the program
- Provide on-line training modules required for training by Healthy Families America
- Accreditation to national evidence based model
- Provide resources to sites
- Provide evaluation guidance in order to meet benchmarks

Subcontract: 10 District Health Depts; 15 Independent Health Centers **$5,661,000**
Purpose: To provide home visitation services to at-risk families outlined in the Federal Legislation in the 39 identified at-risk counties
Estimated costs: Services-$3,711,000; Start-up costs - $1,950,000
Deliverables:

				October 1, 2011 - Sept 30, 2012			
				Year 1 (prenatal)			
District	Rank	County	Multi-gravidas 2008 (#)	25% Family Participation rate	Number of Expected Visits	16 visits x $125 (ave of para & pro visit)	
Barren River	38	EDMONSON	87	22	348	$	43,500
Barren River	40	METCALFE	99	25	396	$	49,500
Barren River	42	BUTLER	129	32	516	$	64,500
			315	**79**	**1260**	**$**	**157,500**
Buffalo Trace	26	MASON	196	49	784	$	98,000
Cumberland Valley	17	JACKSON	98	25	392	$	49,000
Cumberland Valley	18	HARLAN	267	67	1,068	$	133,500

Cumberland Valley	20	CLAY	238		60	952	$	119,000
Cumberland Valley	24	BELL	312		78	1,248	$	156,000
Cumberland Valley	47	ROCKCASTLE	160		40	640	$	80,000
			1075		**269**	**4,300**	**$**	**537,500**
Gateway	9	BATH	91		23	364	$	45,500
Gateway	19	MENIFEE	48		12	192	$	24,000
Gateway	28	ROWAN	235		59	940	$	117,500
Gateway	32	MORGAN	120		30	480	$	60,000
			494		**124**	**1,976**	**$**	**247,000**
Lake Cumberland	27	MCCREARY	166		42	664	$	83,000
Lake Cumberland	29	CUMBERLAND	58		15	232	$	29,000
			224		**56**	**896**	**$**	**112,000**
Lincoln Trail	36	GRAYSON	262		**66**	**1,048**	**$**	**131,000**
Little Sandy	15	ELLIOTT	44		11	176	$	22,000
Little Sandy	22	CARTER	271		68	1,084	$	135,500
			315		**79**	**1,260**	**$**	**157,500**
Pennyrile	45	TRIGG	109		**27**	**436**	**$**	**54,500**
Purchase	21	FULTON	76		19	304	$	38,000
Purchase	35	BALLARD	83		21	332	$	41,500
Purchase	37	HICKMAN	37		9	148	$	18,500
Purchase	43	MCCRACKEN	652		163	2,608	$	326,000
			848		**212**	**3,392**	**$**	**424,000**
Wetico	39	NICHOLAS	86		**22**	**344**	**$**	**43,000**
Independent	3	MAGOFFIN	108		**27**	**432**	**$**	**54,000**
Independent	5	MARTIN	129		**32**	**516**	**$**	**64,500**
Independent	7	FLOYD	317		**79**	**1,268**	**$**	**158,500**
Independent	13	JOHNSON	163		**41**	**652**	**$**	**81,500**
Independent	14	PIKE	429		**107**	**1,716**	**$**	**214,500**
Independent	16	POWELL	112		**28**	**448**	**$**	**56,000**
Independent	23	LEWIS	71		**18**	**284**	**$**	**35,500**
Independent	25	KNOX	381		**95**	**1,524**	**$**	**190,500**

Independent	30	WHITLEY	419	105	1,676	$	209,500
Independent	31	MONTGOMERY	325	81	1,300	$	162,500
Independent	33	ESTILL	159	40	636	$	79,500
Independent	34	BOYD	445	111	1,780	$	222,500
Independent	41	GARRARD	168	42	672	$	84,000
Independent	44	MONROE	120	30	480	$	60,000
Independent	46	FLEMING	152	38	608	$	76,000
TOTAL				1857	29688	$	3,711,000

- Start up costs for 39 counties @$50,000: $1,950,000

Start-up costs	Cost	Definition:
Training Materials	$15,000	Growing Great KIDS Curriculum (@$450 a set); education items supporting multi-gravidas, Core materials, etc
Training	$ 7,500	Salary for staff to attend training, hotel costs, travel, per diem
Outreach to Community	$ 7,500	Salary for staff time, meeting rooms, rental of equipment
Incentives	$10,000	Incentives for families that promote the program goals such as safety in the home
Advertisement	$5,000	Pamphlets, Billboards, Promotional Items
Supplies	$5,000	Items such as craft supplies needed to support the curriculum activities

Subcontract: Every Child Succeeds **$180,000**
Purpose: To train and support 12 full-time mental health specialists to provide in-home therapy to mothers participating in home visitation services that are suffering with depression
Estimated costs: $15,000 for training x 12 FTEs = $180,000
Deliverables:

- Develop Implementation Plan based on site visit and discussions with home visiting agencies.
- Train home visitors and site administration in screening and referral procedures.
- Schedule and provide 12 therapists and doctoral level supervisor with an intensive, three-day training in IH-CBT in Cincinnati.
- Provide therapists and the supervisor with the IH-CBT manual.
- Conduct regularly scheduled on-site and telephone consultations to support therapists in effectively implementing the IH-CBT treatment.
- Review a sample of audiotapes of IH-CBT sessions to ensure quality and fidelity to the treatment model.

Subcontract: Kentucky Mental Health Center (varies areas) **$780,000**
Purpose: To hire 12 full time mental health specialists to provide in-home therapy to mothers participating in home visitation services that are suffering with depression
Estimated costs: $65,000 annual salary and fringe x 12 = $780,000
Deliverables:

- Hire 12 full-time individuals with Masters-level training in social work, psychology, or counseling (ML) and with prior training in Cognitive Behavioral Therapy to serve as therapists and implement the Program.
- Cover travel expenses for therapists to attend Cincinnati training.
- Ensure home visiting site cooperation with and engagement in MDTP implementation.
- Systematically screen mothers in home visiting using a standard depression screen in order to generate referrals into the MDTP program.
- Ensure therapists attend a three-day cognitive behavioral therapy refresher training at the Beck Institute in Philadelphia or equivalent CBT immersion experience prior to participating in the Program training. Cover travel and training costs for this experience.
- Provide data on program implementation and outcomes to facilitate comparison to Cincinnati experiences with MDTP.

Subcontract: External Evaluator **$100,000**
Purpose: To evaluate the home visiting expansion according to the methodology outlined in the proposal
Estimated costs: $100,000
Deliverables:

- Collaborate in planning, implementing and support of statewide home visitation program databases for MCH. Prepare reports, charts, graphs as well as presentations.
- Assess adequacy of data available for analysis and conduct studies to indentify populations at risk. Assist in formation of hypothesis to explain data.
- Coordinate efforts to improve overall data system for Maternal and Child Health and applies scientific sampling techniques for use in studies. Performs analysis on data for benchmark monitoring.
- Other duties as assigned including technical support for participant and prepare information for federal grant reporting and related Maternal and Child Health initiatives.

Subcontract: CHFS IT **$125,000**
(Cabinet for Health and Family Services Information Technology)
Purpose: Programming will be needed to make modification to the current web-based system to accommodate additional data collection for the program to provide specific data on high-risk populations for analysis and to capture data that will be needed to measure benchmarks at 3 and 5 years.
Estimated costs: $125,000 - Salary for one programmer ($65/hr @40 hours a week/240 days a year)
Deliverables:

- Data collected processes for eligible families that have been enrolled in the program who receive services funded with the MIECHV Program funds on all benchmark areas
- Each benchmark area includes multiple constructs. Collection of data for all constructs under each benchmark area.
- To provide a method of demonstrating improvements in at least four benchmark areas by the end of three years.

Indirect Costs: **$8,527**

Twenty-two percent is the indirect rate applied only to salaries in federal applications by Kentucky.

FY11 Salaries: $ 38,760 x 22% = $8,527

FY12 Budget

Expense Category	Total Costs
Personnel-Salary and Wage	**$40,698**
Fringe Benefits	**$20,200**
Travel	**$4,786**
Equipment	
Supplies	**$1,500**
Contracts	**$6,803,888**
Other	
Total Direct Charges	**$6,871,072**
Indirect	**$8,954**
Total Requested	**$6,880,026**

Personnel Costs: **$40,698**

The role of Technical Consultant for Healthy Families America will streamline the process of accreditation. This will be a full-time position and the estimated annual salary will be $40,698. The Technical Consultant will serve as a systems coordinator and work with at-risk county and HFA to ensure the standards of the proven home visitation model.

Technical Consultant X 12 months $40,698

Fringe Benefits: **$17,500**

The Fringe Benefits will be approximately $20,200 (FICA @ 7.65%; Retirement @ 19.82%; and Health and Life benefits @ an estimated $9,000). The fringe benefits are directly proportional to that portion of personnel costs that are allocated for the project.

Technical Consultant X 12 months $17,500

Travel: **$4,786**

In State Travel will be necessary to work with the 39 at-risk counties to incorporate a universal screening, collaboration with other home visitation programs and to ensure benchmark data is being completed and HFA standards are achieved.

38 trips X 100 miles @0.47 per mile $1,786

Out of State Travel to attend required grantee meeting $3,000

Supplies: **$1,500**

Supplies X 12 months

Paper, pens $500

Postage 1,000 letters at .44 ea $440
Flip Charts, markers, highlighters, binders $560

Subcontracts: **$6,803,888**

Subcontract: Healthy Families America **$52,388**
Purpose: To join an evidence based model approved through HomVEE
Estimated costs:

- Large site fee: ($1350) x 19 sites = $25,650
- Small site fee: ($675) x 6 sites = $4,050
- Technical assistance site visits: 60% of sites receive review every 4 years @$2,000 per visits = $7,500
- Application Fee: Every four years there is an application fee = $750 (average of $188 per year for four years)
- HFA Evaluation Contract = $15,000

Deliverables:

- Provide technical assistance and on-site evaluation of the program
- Provide on-line training modules required for training by Healthy Families America
- Accreditation to national evidence based model
- Provide resources to sites
- Provide evaluation guidance in order to meet benchmarks

Subcontract: 10 District Health Depts; 15 Independent Health Centers **$5,566,500**
Purpose: To provide home visitation services to at-risk families outlined in the Federal Legislation in the 39 identified at-risk counties
Estimated costs: Services-$5,566,500
Deliverables:

				October 1, 2012 - Sept 30, 2013		
				Year 2 (0-12 mos)		
District	Rank	County	Multi-gravidas 2008 (#)	25% Family Participation rate	Number of Expected Visits	16 visits x $125 (ave of para & pro visit)
Barren River	38	EDMONSON	87	33	522	$ 65,250
Barren River	40	METCALFE	99	37	594	$ 74,250
Barren River	42	BUTLER	129	48	774	$ 96,750
			315	118	1890	$ 236,250
Buffalo Trace	26	MASON	196	74	1176	$ 147,000
Cumberland Valley	17	JACKSON	98	37	588	$ 73,500
Cumberland Valley	18	HARLAN	267	100	1602	$ 200,250
Cumberland Valley	20	CLAY	238	89	1428	$ 178,500

Cumberland Valley	24	BELL	312	117	1872	$	234,000
Cumberland Valley	47	ROCKCASTLE	160	60	960	$	120,000
				403	6450	$	806,250

Gateway	9	BATH	91	34	546	$	68,250
Gateway	19	MENIFEE	48	18	288	$	36,000
Gateway	28	ROWAN	235	88	1410	$	176,250
Gateway	32	MORGAN	120	45	720	$	90,000
				185	2964	$	370,500

Lake Cumberland	27	MCCREARY	166	62	996	$	124,500
Lake Cumberland	29	CUMBERLAND	58	22	348	$	43,500
				84	1344	$	168,000

Lincoln Trail	36	GRAYSON	262	98	1572	$	196,500

Little Sandy	15	ELLIOTT	44	17	264	$	33,000
Little Sandy	22	CARTER	271	102	1626	$	203,250
				118	1890	$	236,250

Pennyrile	45	TRIGG	109	41	654	$	81,750

Purchase	21	FULTON	76	29	456	$	57,000
Purchase	35	BALLARD	83	31	498	$	62,250
Purchase	37	HICKMAN	37	14	222	$	27,750
Purchase	43	MCCRACKEN	652	245	3912	$	489,000
				318	5088	$	636,000

Wedco	39	NICHOLAS	86	32	516	$	64,500

Independent	3	MAGOFFIN	108	41	648	$	81,000
Independent	5	MARTIN	129	48	774	$	96,750
Independent	7	FLOYD	317	119	1902	$	237,750
Independent	13	JOHNSON	163	61	978	$	122,250
Independent	14	PIKE	429	161	2574	$	321,750
Independent	16	POWELL	112	42	672	$	84,000
Independent	23	LEWIS	71	27	426	$	53,250
Independent	25	KNOX	381	143	2286	$	285,750
Independent	30	WHITLEY	419	157	2514	$	314,250
Independent	31	MONTGOMERY	325	122	1950	$	243,750
Independent	33	ESTILL	159	60	954	$	119,250

Independent	34	BOYD	445	167	2670	$	333,750
Independent	41	GARRARD	168	63	1008	$	126,000
Independent	44	MONROE	120	45	720	$	90,000
Independent	46	FLEMING	152	57	912	$	114,000
TOTAL				2783	44532	$	5,566,500

Subcontract: Every Child Succeeds **$180,000**
Purpose: To train and support 12 full-time mental health specialists to provide in-home therapy to mothers participating in home visitation services that are suffering with depression
Estimated costs: $15,000 for training x 12 FTEs = $180,000
Deliverables:

- Develop Implementation Plan based on site visit and discussions with home visiting agencies.
- Train home visitors and site administration in screening and referral procedures.
- Schedule and provide 12 therapists and doctoral level supervisor with an intensive, three-day training in IH-CBT in Cincinnati.
- Provide therapists and the supervisor with the IH-CBT manual.
- Conduct regularly scheduled on-site and telephone consultations to support therapists in effectively implementing the IH-CBT treatment.
- Review a sample of audiotapes of IH-CBT sessions to ensure quality and fidelity to the treatment model.

Subcontract: Kentucky Mental Health Center (varies areas) **$780,000**
Purpose: To maintain 12 full time mental health specialists to provide in-home therapy to mothers participating in home visitation services that are suffering with depression
Estimated costs: $65,000 annual salary and fringe x 12 = $780,000
Deliverables:

- Maintain 12 full-time individuals with Masters-level training in social work, psychology, or counseling (ML) and with prior training in Cognitive Behavioral Therapy to serve as therapists and implement the Program.
- Cover travel expenses for therapists to attend Cincinnati training.
- Ensure home visiting site cooperation with and engagement in MDTP implementation.
- Systematically screen mothers in home visiting using a standard depression screen in order to generate referrals into the MDTP program.
- Ensure therapists attend a three-day cognitive behavioral therapy refresher training at the Beck Institute in Philadelphia or equivalent CBT immersion experience prior to participating in the Program training. Cover travel and training costs for this experience.
- Provide data on program implementation and outcomes to facilitate comparison to Cincinnati experiences with MDTP.

Subcontract: External Evaluator **$100,000**
Purpose: To evaluate the home visiting expansion according to the methodology outlined in the proposal
Estimated costs: $100,000

Deliverables:

- Collaborate in planning, implementing and support of statewide home visitation program databases for MCH. Prepare reports, charts, graphs as well as presentations.
- Assess adequacy of data available for analysis and conduct studies to indentify populations at risk. Assist in formation of hypothesis to explain data.
- Coordinate efforts to improve overall data system for Maternal and Child Health and applies scientific sampling techniques for use in studies. Performs analysis on data for benchmark monitoring.
- Other duties as assigned including technical support for participant and prepare information for federal grant reporting and related Maternal and Child Health initiatives.

$125,000

Subcontract: CHFS IT
(Cabinet for Health and Family Services Information Technology)
Purpose: Programming will be needed to make modification to the current web-based system to accommodate additional data collection for the program to provide specific data on high-risk populations for analysis and to capture data that will be needed to measure benchmarks at 3 and 5 years.
Estimated costs: $125,000 - Salary for one programmer ($65/hr @40 hours a week/240 days a year)
Deliverables:

- Data collected processes for eligible families that have been enrolled in the program who receive services funded with the MIECHV Program funds on all benchmark areas
- Each benchmark area includes multiple constructs. Collection of data for all constructs under each benchmark area.
- To provide a method of demonstrating improvements in at least four benchmark areas by the end of three years.

$8,954

Indirect Costs:
Twenty-two percent is the indirect rate applied only to salaries in federal applications by Kentucky.

FY12 Salaries: $ 40,698 x 22% = $8,954

FY13 Budget

Expense Category	Total Costs
Personnel-Salary and Wage	$42,733
Fringe Benefits	$18,375
Travel	$4,786
Equipment	
Supplies	$1,500
Contracts	$9,165,388
Other	
Total Direct Charges	$9,232,782
Indirect	$9,401
Total Requested	$9,242,183

Personnel Costs: $42,733

The role of Technical Consultant for Healthy Families America will streamline the process of accreditation. This will be a full-time position and the estimated annual salary will be $42,733. The Technical Consultant will serve as a systems coordinator and work with at-risk county and HFA to ensure the standards of the proven home visitation model.

Technical Consultant X 12 months $42,733

Fringe Benefits: **$18,375**

The Fringe Benefits will be 43% of the annual salary and they will include FICA, retirement, health insurance, unemployment insurance, life insurance. The fringe benefits are directly proportional to that portion of personnel costs that are allocated for the project.

Technical Consultant X 12 months $18,375

Travel: **$4,786**

In State Travel will be necessary to work with the 39 at-risk counties to incorporate a universal screening, collaboration with other home visitation programs and to ensure benchmark data is being completed and HFA standards are achieved.

38 trips X 100 miles @0.47 per mile $1,786

Out of State Travel to attend required grantee meeting $3,000

Supplies: **$1,500**

Supplies X 12 months

Paper, pens	$500
Postage 1,000 letters at .44 ea	$440
Flip Charts, markers, highlighters, binders	$560

Subcontracts: **$9,165,388**

Subcontract: Healthy Families America **$37,388**

Purpose: To join an evidence based model approved through HomVEE

Estimated costs:

- Large site fee: ($1350) x 19 sites = $25,650
- Small site fee: ($675) x 6 sites = $4,050
- Technical assistance site visits: 60% of sites receive review every 4 years @$2,000 per visits = $7,500
- Application Fee: Every four years there is an application fee = $750 (average of $188 per year for four years)

Deliverables:

- Provide technical assistance and on-site evaluation of the program
- Provide on-line training modules required for training by Healthy Families America
- Accreditation to national evidence based model

- Provide resources to sites

Subcontract: 10 District Health Depts; 15 Independent Health Centers **$8,248,000**
Purpose: To provide home visitation services to at-risk families outlined in the Federal Legislation in the 39 identified at-risk counties
Estimated costs: Services-$8,248,000
Deliverables:

				October 1, 2013 - Sept 30, 2014		
				Year 3 (13-24 mos)		
District	Rank	County	Multi-gravidas 2008 (#)	25% Family Participation rate	Number of Expected Visits	16 visits x $125 (ave of para & pro visit)
Barren River	38	EDMONSON	87	49	783	$ 97,875
Barren River	40	METCALFE	99	56	891	$ 111,375
Barren River	42	BUTLER	129	73	1161	$ 145,125
			315	177	2835	$ 354,375
Buffalo Trace	26	MASON	196	110	1764	$ 220,500
Cumberland Valley	17	JACKSON	98	55	882	$ 110,250
Cumberland Valley	18	HARLAN	267	150	2403	$ 300,375
Cumberland Valley	20	CLAY	238	83	1328	$ 166,000
Cumberland Valley	24	BELL	312	176	2808	$ 351,000
Cumberland Valley	47	ROCKCASTLE	160	90	1440	$ 180,000
				554	8861	$ 1,107,625
Gateway	9	BATH	91	51	819	$ 102,375
Gateway	19	MENIFEE	48	27	432	$ 54,000
Gateway	28	ROWAN	235	132	2115	$ 264,375
Gateway	32	MORGAN	120	68	1080	$ 135,000
				278	4446	$ 555,750
Lake Cumberland	27	MCCREARY	166	93	1494	$ 186,750
Lake Cumberland	29	CUMBERLAND	58	33	522	$ 65,250
				126	2016	$ 252,000
Lincoln Trail	36	GRAYSON	262	147	2358	$ 294,750
Little Sandy	15	ELLIOTT	44	25	396	$ 49,500
Little Sandy	22	CARTER	271	152	2439	$ 304,875

				177	2835	$ 354,375
Pennyrile	45	TRIGG	109	61	981	$ 122,625

Purchase	21	FULTON	76	43	684	$ 85,500
Purchase	35	BALLARD	83	47	747	$ 93,375
Purchase	37	HICKMAN	37	21	333	$ 41,625
Purchase	43	MCCRACKEN	652	367	5868	$ 733,500
				477	7632	$ 954,000
Wedco	39	NICHOLAS	86	48	774	$ 96,750

Independent	3	MAGOFFIN	108	61	972	$ 121,500
Independent	5	MARTIN	129	73	1161	$ 145,125
Independent	7	FLOYD	317	178	2853	$ 356,625
Independent	13	JOHNSON	163	92	1467	$ 183,375
Independent	14	PIKE	429	241	3861	$ 482,625
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Independent	23	LEWIS	71	40	639	$ 79,875
Independent	25	KNOX	381	214	3429	$ 428,625
Independent	30	WHITLEY	419	236	3771	$ 471,375
Independent	31	MONTGOMERY	325	183	2925	$ 365,625
Independent	33	ESTILL	159	89	1431	$ 178,875
Independent	34	BOYD	445	250	4005	$ 500,625
Independent	41	GARRARD	168	95	1512	$ 189,000
Independent	44	MONROE	120	68	1080	$ 135,000
Independent	46	FLEMING	152	86	1368	$ 171,000

TOTAL				4124	65984	$ 8,248,000

Subcontract: Kentucky Mental Health Center (varies areas) **$780,000**
Purpose: To maintain12 full time mental health specialists to provide in-home therapy to mothers participating in home visitation services that are suffering with depression
Estimated costs: $65,000 annual salary and fringe x 12 = $780,000
Deliverables:

- Maintain 12 full-time individuals with Masters-level training in social work, psychology, or counseling (ML) and with prior training in Cognitive Behavioral Therapy to serve as therapists and implement the Program.
- Cover travel expenses for therapists to attend Cincinnati training.
- Ensure home visiting site cooperation with and engagement in MDTP implementation.
- Systematically screen mothers in home visiting using a standard depression screen in order to generate referrals into the MDTP program.
- Ensure therapists attend a three-day cognitive behavioral therapy refresher training at the Beck Institute in Philadelphia or equivalent CBT immersion experience prior to participating in the Program training. Cover travel and training costs for this experience.

- Provide data on program implementation and outcomes to facilitate comparison to Cincinnati experiences with MDTP.

Subcontract: External Evaluator **$100,000**
Purpose: To evaluate the home visiting expansion according to the methodology outlined in the proposal
Estimated costs: $100,000
Deliverables:

- Collaborate in planning, implementing and support of statewide home visitation program databases for MCH. Prepare reports, charts, graphs as well as presentations.
- Assess adequacy of data available for analysis and conduct studies to indentify populations at risk. Assist in formation of hypothesis to explain data.
- Coordinate efforts to improve overall data system for Maternal and Child Health and applies scientific sampling techniques for use in studies. Performs analysis on data for benchmark monitoring.
- Other duties as assigned including technical support for participant and prepare information for federal grant reporting and related Maternal and Child Health initiatives.

Indirect Costs: **$9,401**
Twenty-two percent is the indirect rate applied only to salaries in federal applications by Kentucky.

FY13 Salaries: $ 42,733 x 22% = $9,401

FY14 Budget

Expense Category	Total Costs
Personnel-Salary and Wage	$44,870
Fringe Benefits	$19,294
Travel	$4,786
Equipment	
Supplies	$1,500
Contracts	$9,165,388
Other	
Total Direct Charges	$9,235,838
Indirect	$9,871
Total Requested	$9,245,709

Personnel Costs: **$44,870**
The role of Technical Consultant for Healthy Families America will streamline the process of accreditation. This will be a full-time position and the estimated annual salary will be $44,870. The Technical Consultant will serve as a systems coordinator and work with at-risk county and HFA to ensure the standards of the proven home visitation model.
Technical Consultant X 12 months $44,870

Fringe Benefits: **$19,294**

The Fringe Benefits will be 43% of the annual salary and they will include FICA, retirement, health insurance, unemployment insurance, life insurance. The fringe benefits are directly proportional to that portion of personnel costs that are allocated for the project.

Technical Consultant	X 12 months	$19,294

Travel: **$4,786**

In State Travel will be necessary to work with the 39 at-risk counties to incorporate a universal screening, collaboration with other home visitation programs and to ensure benchmark data is being completed and HFA standards are achieved.

38 trips X 100 miles @0.47 per mile	$1,786
Out of State Travel to attend required grantee meeting	$3,000

Supplies: **$1,500**

Supplies X 12 months

Paper, pens	$500
Postage 1,000 letters at .44 ea	$440
Flip Charts, markers, highlighters, binders	$560

Subcontracts: **$9,165,388**

Subcontract: Healthy Families America **$37,388**

Purpose: To join an evidence based model approved through HomVEE

Estimated costs:

- Large site fee: ($1350) x 19 sites = $25,650
- Small site fee: ($675) x 6 sites = $4,050
- Technical assistance site visits: 60% of sites receive review every 4 years @$2,000 per visits = $7,500
- Application Fee: Every four years there is an application fee = $750 (average of $188 per year for four years)

Deliverables:

- Provide technical assistance and on-site evaluation of the program
- Provide on-line training modules required for training by Healthy Families America
- Accreditation to national evidence based model
- Provide resources to sites

Subcontract: 10 District Health Depts; 15 Independent Health Centers **$8,248,000**

Purpose: To provide home visitation services to at-risk families outlined in the Federal Legislation in the 39 identified at-risk counties

Estimated costs: Services-$8,248,000

Deliverables:

				30, 2015		
				Year 4 (ongoing cost)		
District	Rank	County	Multi-gravidas 2008 (#)	25% Family Participation rate	Number of Expected Visits	16 visits x $125 (ave of para & pro visit)
Barren River	38	EDMONSON	87	49	783	$ 97,875
Barren River	40	METCALFE	99	56	891	$ 111,375
Barren River	42	BUTLER	129	73	1161	$ 145,125
			315	177	2835	$ 354,375
Buffalo Trace	26	MASON	196	110	1764	$ 220,500
Cumberland Valley	17	JACKSON	98	55	882	$ 110,250
Cumberland Valley	18	HARLAN	267	150	2403	$ 300,375
Cumberland Valley	20	CLAY	238	83	1328	$ 166,000
Cumberland Valley	24	BELL	312	176	2808	$ 351,000
Cumberland Valley	47	ROCKCASTLE	160	90	1440	$ 180,000
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Indirect Costs: **$9,871**

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FY14 Salaries: $ 44,870 x 22% = $9,871